

09187

CERTIFICATE OF DEATH

09179

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN lb <b>8 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>MRS. ANNA J. BARKER</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>23</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/16/99</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>W. VA.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>FRANK KNIGHT</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA HARTLEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>236-74-054</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Unknown - CVA</b> DUE TO <b>Hypertensive Cerebro Vascular Disease</b> (Hypertensive cerebro vascular disease) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 17, 1966</b> to <b>July 23, 1966</b> that (I) (we) last saw the deceased alive on <b>July 23, 1966</b> and that death occurred at <b>8:40 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/25/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. QUELTON</b>				22d. ADDRESS <b>133 VA AVE. S. CENTRE ST. CUMBERLAND, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/26/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CAMP HILL</b>		23d. LOCATION (City or town) (County) (State) <b>PAW PAW, W. VA.</b>	
24. FUNERAL DIRECTOR <b>JOHNSON FUNERAL HOME, Spp. W. Va.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 27 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09180

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Years</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>512 Fort Avenue</u>			d. STREET ADDRESS <u>512 Fort Avenue</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Lowell</u> Last <u>Barnes</u>			4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 6, 1923</u>		9. AGE (In years last birthday) <u>43 yrs.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electric Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O R R</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			13. FATHER'S NAME <u>Rollie Barnes</u>		
14. MOTHER'S MAIDEN NAME <u>Dolcie Imes</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>217-18-4551</u>			17. INFORMANT <u>Mr. Rollie I. Barnes, 479 Fort Ave-Cumberland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot of Head</u> 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>(Self Inflicted)</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>July 26, 1966</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	
23d. LOCATION (City, town or county) <u>Near Cumberland, Md.</u>					
24. FUNERAL DIRECTOR <u>John J. Hafer</u>		ADDRESS <u>John J. Hafer, 230 Balto Ave., Cumberland, Md</u>		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "RECEIVED" and "DATE" are faintly visible.]*

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JUL 25 1968

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09183

09181

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>50 North Mechanic Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>J.</b> Last <b>Barnhart</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1909</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Barnhart</b>		14. MOTHER'S MAIDEN NAME <b>Sarah R. Barnhart</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sara R. Barnhart</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: } (b) <b>Coronary Thrombosis</b> DUE TO (c) <b>Coronary Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 5, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 7, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenway Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Berkley Springs, W. Va.</b>	
24. FUNERAL DIRECTOR <b>Philip B. Wendt 121 Mem. Ave. Cumb., Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Bedford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>Chaneyville Road</b>	
3. NAME OF DECEASED (Type or print) First <b>SIMEON</b> Middle <b>--</b> Last <b>BORROR</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-27-1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	9. AGE (In years last birthday) <b>80</b>
11. BIRTHPLACE (County & State, or foreign country) <b>PETERSBURG, W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN M. BORROR</b>		14. MOTHER'S MAIDEN NAME <b>SARAH KESNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>174-18-1045A</b>	
17. INFORMANT <b>Mrs. Edna Miller</b>		Address <b>Potomac Park, MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1621</b> IMMEDIATE CAUSE (a) <b>Prochylone Chemic</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic Cardiovascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 <b>1966</b> , that (I) (we) last saw the deceased alive on <b>July 16</b> , 19 <b>66</b> , and that death occurred at <b>12:10</b> from <b>causes</b> and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/15/66</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Assembly of God Ch. Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Chaneyville, Bedford, Penna</b>
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		25a. REC'D BY REGISTRAR <b>JUL 19 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09191

## CERTIFICATE OF DEATH

09183

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN 1b <b>31 DAYS</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>113 UTAH AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JUNE</b> Middle <b>MARIE</b> Last <b>BRADY</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>6</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-1921</b>		9. AGE (In years last birthday) yrs. <b>44</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>WILLIAM F. LEUTERT</b>				14. MOTHER'S MAIDEN NAME <b>LAURA L. WILKES</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Coma</b> <b>2842</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Chronic Hepatitis</b> DUE TO (c) <b>Collagenous Disease</b> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>58</b> to <b>July 6</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>July 5</b> , 19 <b>66</b> and that death occurred at <b>2:55 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>[Signature]</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. O. HIMMELWRIGHT</b>				22d. ADDRESS <b>133 VIRGINIA AVE.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. - Allegany</b>	
24. FUNERAL DIRECTOR ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

00191

ALLEGANY

CHERRY AND

MEMORIAL HOSPITAL

WOMEN

TIME 11:15

WILLIAM E. JACOB

31 DAYS

CHERRY AND

111 MAIN AVE.

DEPT.

P-3-1231

COMPTON, W.

1000 E. 1000

1000 E. 1000

1000

1000

1000

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in Items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on any event within 72 hours after death.

09192

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09184

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN IL <b>11 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bertha May Brotemarkle</b>		4. DATE OF DEATH Month <b>July</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 11, 1883</b>
9. AGE (in years last birthday) <b>83 yrs</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Housekeeper - At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Kerns</b>		14. MOTHER'S MAIDEN NAME <b>Phoebe Roth</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-52-9768</b>	
17. INFORMANT <b>Mrs. Howard Durst</b>		Address <b>Route #3 Cumberland, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Myocarditis, Cardiac Failure</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <b>Arteriosclerotic Cardiovascular Disease</b> --- (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <b>Fracture of Right Hip</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fell at Home</b>	
20c. TIME OF INJURY Month, Day Year <b>12:30 pm June 27 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 7, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/10/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alleg Rt3 Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland 21502</b>	
25a. REC'D BY REGISTRAR <b>JUL 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>W. J. Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or reinterment, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09193

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09185

1 PLACE OF DEATH a COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Allegany</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cumberland</b>		c LENGTH OF STAY IN 1b <b>35 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>731 Gephart Drive</b>		d STREET ADDRESS <b>731 Gephart Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>P.</b> Last <b>Carlomany</b>		4 DATE OF DEATH Month <b>July</b> Day <b>31</b> Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Dec. 5, 1908</b>
9 AGE (in years last birthday) <b>57 yrs</b>		10 IF UNDER 1 YEAR Months <b>31</b> Days <b>9</b> Hours <b>66</b> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of waking life even if retired) <b>Builder-in-Contractor</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11 BIRTHPLACE (State or foreign country) <b>Clarksburg, W. Va.</b>		12 CITIZEN OF WHAT COUNTRY <b>USA</b>	
13 FATHER'S NAME <b>Joseph Carlomany</b>		14 MOTHER'S MAIDEN NAME <b>Mary Jurick</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO. <b>no</b>	
17 INFORMANT <b>Mrs. Catherine Carlomany, Cumberland, Md.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS, LEFT</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)		INTERVAL BETWEEN ONSET AND DEATH MINUTES <b>---</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>Aug. 31, 1966</b> 22. DATE SIGNED	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <b>Rt. 9 Cumberland</b>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>Aug. 3, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul Cemetery</b>	23d LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>
24 FUNERAL DIRECTOR <b>James F. Scarpetti, Cumberland, Md.</b>		25a REC'D BY REGISTRAR <b>DATE AUG 2 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





09194

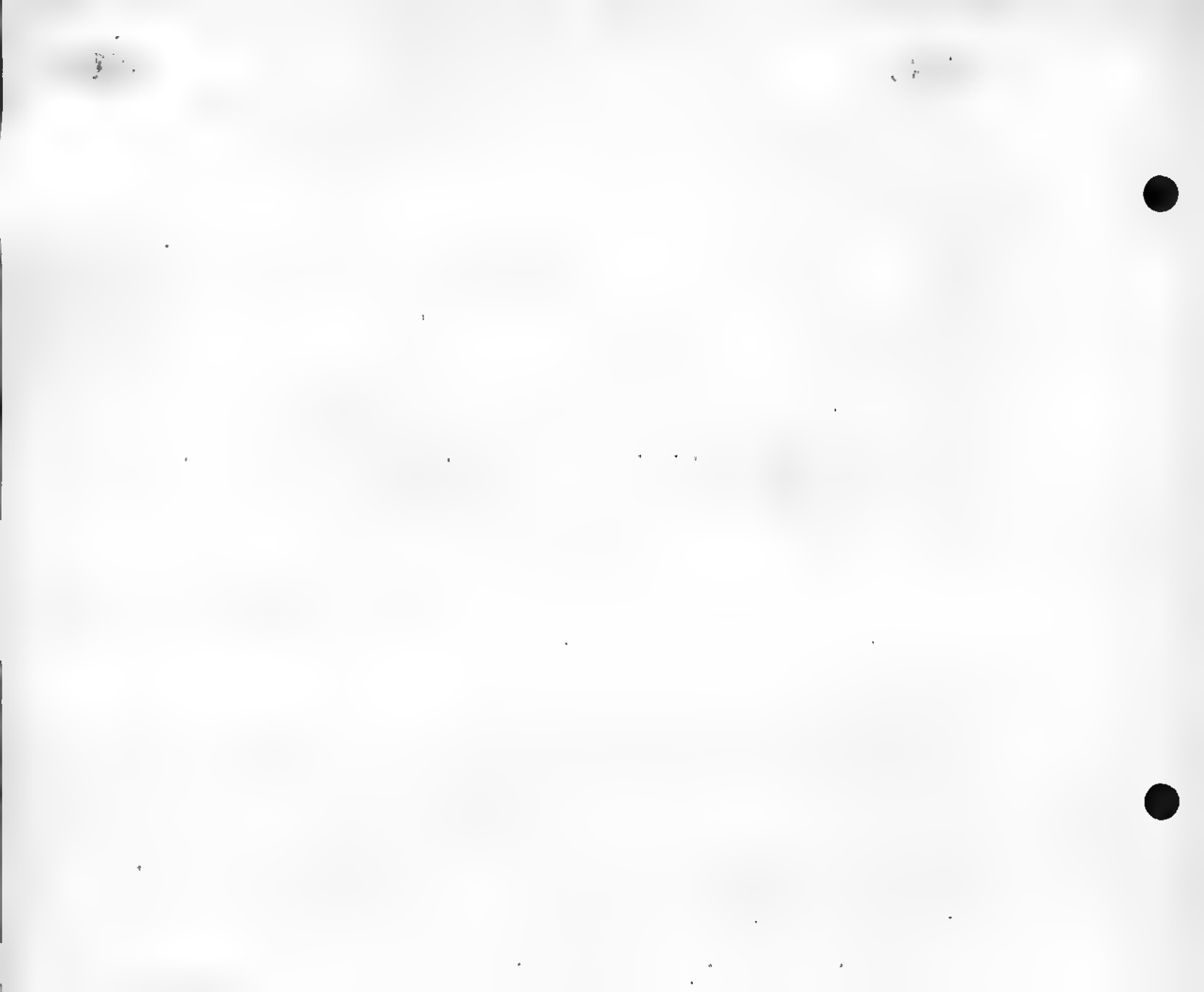
## CERTIFICATE OF DEATH

09186

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		d. STREET ADDRESS <b>111 WOOD STREET</b>	
3 NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>IMOGENE</b> Last <b>CAUDILL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> , Year <b>66</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 6, 1897</b>
9 AGE (In years last birthday) <b>69</b> yrs		10. BIRTHPLACE (County & State, or foreign country) <b>VIRGINIA</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TEACHER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>	
11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS CAUDILL</b>		14. MOTHER'S MAIDEN NAME <b>JULIA FRENCH</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>212-38-5544</b>		16 SOCIAL SECURITY NO. <b>212-38-5544</b>	
17. INFORMANT <b>PERRY W. MYERS, FROSTBURG, MD.</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Arteriosclerotic CVD</b> DUE TO (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes 2 Adrenal Insufficiency</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>✓</b> 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE, 1960</b> , to <b>7/11, 1966</b> that (I) (we) last saw the deceased alive on <b>7/11, 1966</b> , and that death occurred at <b>5:50 PM</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Martin Rothstein M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b DATE SIGNED <b>7/11/66</b>
22c. PHYSICIAN'S NAME (Type) <b>MARTIN ROTHSTEIN, M. D.</b>		22d. ADDRESS <b>BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JULY 14, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MAPLE HILL CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>BLUEFIELD, VIRGINIA</b>
24 FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



09195

CERTIFICATE OF DEATH

09187

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>W. VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>9 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <i>c/o Postmaster</i>	
3. NAME OF DECEASED (Type or print) First <b>PHILLIP</b> Middle <b>W.</b> Last <b>CLINGERMAN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-1907</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NET. RAIL ROADER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.R.</b>	
11. BIRTHPLACE (County & State or foreign country) <b>W. VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN W. CLINGERMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH CHANEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>234-52-6355</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Art. death CVD and Chronic Arterio</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Chronic Arterio</b> (c) DUE TO <b>—</b>		INTERVA. BETWEEN ONSET AND DEATH <b>2 yrs 6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. — p.m. — 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland Md</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7/13/66</b> to <b>7/15/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/13/66</b> , and that death occurred at <b>8:00 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>R. J. Williams</i>		22b. DATE SIGNED <b>7/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Great Cacapon, W. Va.</b>	
24. FUNERAL DIRECTOR <i>Johnson Funeral Homes</i>		25a. REC'D BY REGISTRAR <b>W. Va.</b>	
25b. REGISTRAR'S SIGNATURE <i>Johnson</i>		25c. DATE <b>JUL 18 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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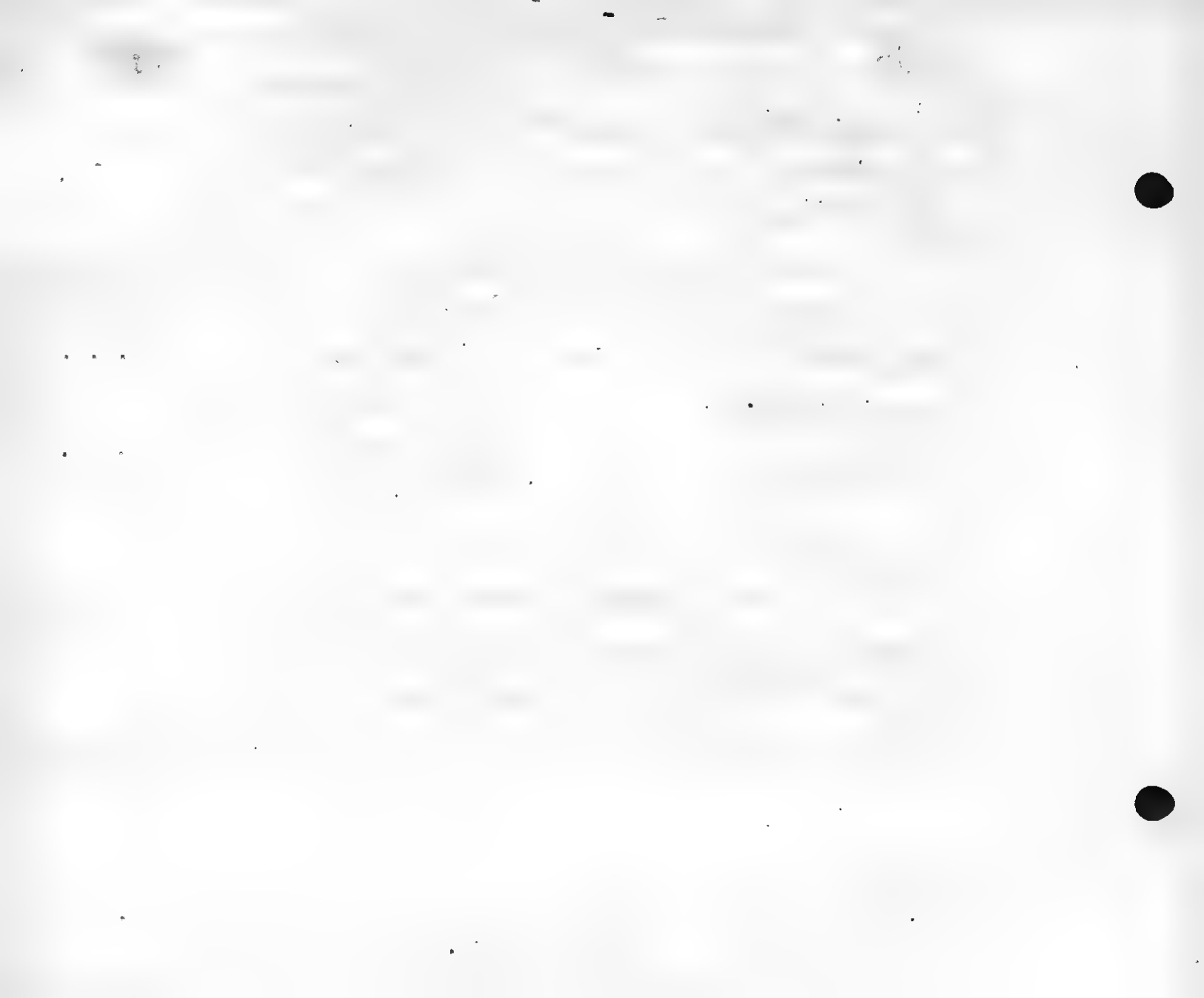
VR A15 (4)  
20M 1/65

**MARYLAND-STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

09196

09188

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Kyle Nurseing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Cooper</b> Last <b>Cooper</b>				4. DATE OF DEATH Month <b>July</b> Day <b>29</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/25/1889</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>29</b> Hours <b>11</b> Min.		IF UNDER 24 HRS. Hours <b>11</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mine</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Midlothian, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Alfred W. Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Amy Emily Thomas</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>George Cooper</b> Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Ischemia</b> + <b>ACVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>due to</b> (c) <b>years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 27, 1966</b> , to <b>July 29, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 27, 1966</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>L.R. Miles</b>				22b. DATE SIGNED <b>7-30-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>L.R. MILES JR MD</b>				22d. ADDRESS <b>LONA CONING MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Lonaconing, Md.</b>	
24. FUNERAL DIRECTOR <b>George Eichhorn</b>				25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							





FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

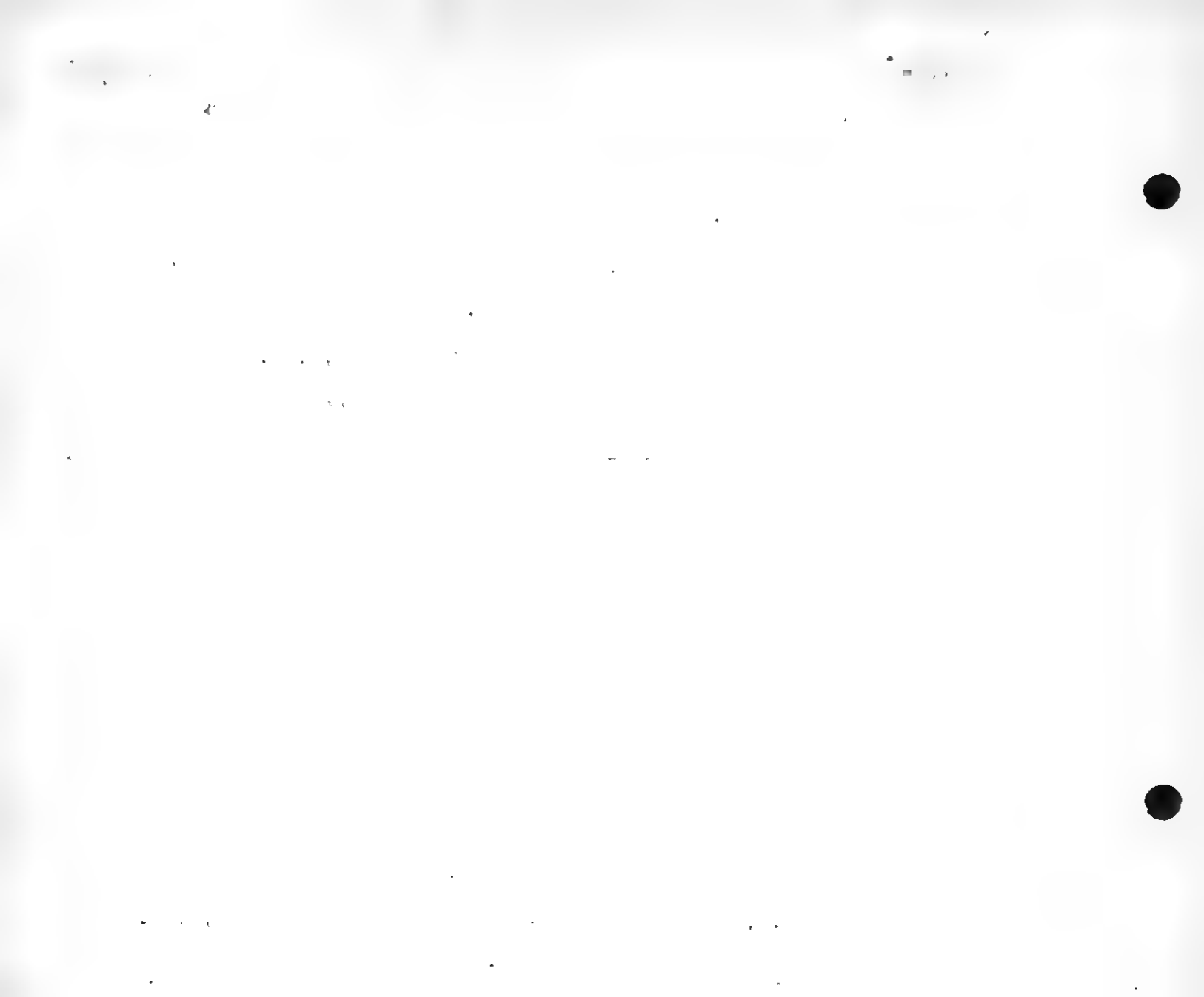
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09189

09197

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>438 Goethe St.</b>		d. STREET ADDRESS <b>438 Goethe St</b>	
3. NAME OF DECEASED (Type or print) First <b>Elwood</b> Middle <b>C.</b> Last <b>Copeland</b>		4. DATE OF DEATH Month <b>July</b> Day <b>30th</b> , Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 15, 1917</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Type setter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Newspaper</b>	9. AGE (in years last birthday) <b>49</b> yrs
11. BIRTHPLACE (State or foreign country) <b>Williamsport, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hugh Copeland</b>		14. MOTHER'S MAIDEN NAME <b>Edna Hattris</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II-Korean</b>		16. SOCIAL SECURITY NO <b>214-07-3886</b>	17. INFORMANT <b>Mr. Elwood Copeland</b> Address <b>Cumberland Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot of head</b> DUE TO (b) <b>(Self inflicted)</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarolic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarolic</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <b>Cumberland, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 2, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Headsville Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Headsville, W. Va.</b>
24. FUNERAL DIRECTOR <b>Allen M. Rotruck</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 2 1966</b>	
ADDRESS <b>Keyser, West Va.</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

52

<div> <div>1</div> <div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div> <div>09193</div> <div>CERTIFICATE OF DEATH</div> <div>09190</div> </div> </div> </div>									
1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Sacred Heart Hospital</b>					d. STREET ADDRESS <b>307 Baltimore Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Perry</b> Middle <b>G.</b> Last <b>Corwell</b>					4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>1966</b>				
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-5-85 (1885)</b>		9. AGE (In years birth day) yrs. <b>81</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPL. (County & State, or foreign country) <b>Gettysburg Maryland Pa.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathaniel Corwell</b>					14. MOTHER'S MAIDEN NAME <b>Sarah Twigg</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO		17. INFORMANT <b>Patient's chart</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular accident</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Osteoarthritis</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>7-9</b> , <b>1962</b> , to <b>7-17</b> , <b>1966</b> , that (I) (we) last saw the deceased alive on <b>7-16</b> , <b>1966</b> , and that death occurred at <b>3</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>Leah B. Ballin</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-17-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>					22d. ADDRESS <b>62 Greene St., Cumberland, Md. 21502</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 19, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cemetery</b>			23d. LOCATION (City or town) (County) (State) <b>Near Cumberland, Md. Allegany</b>		
24. FUNERAL DIRECTOR <b>James F. Scarrelli, Cumberland, Md.</b>					25a. RECD BY REGISTRAR DATE <b>JUL 20 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

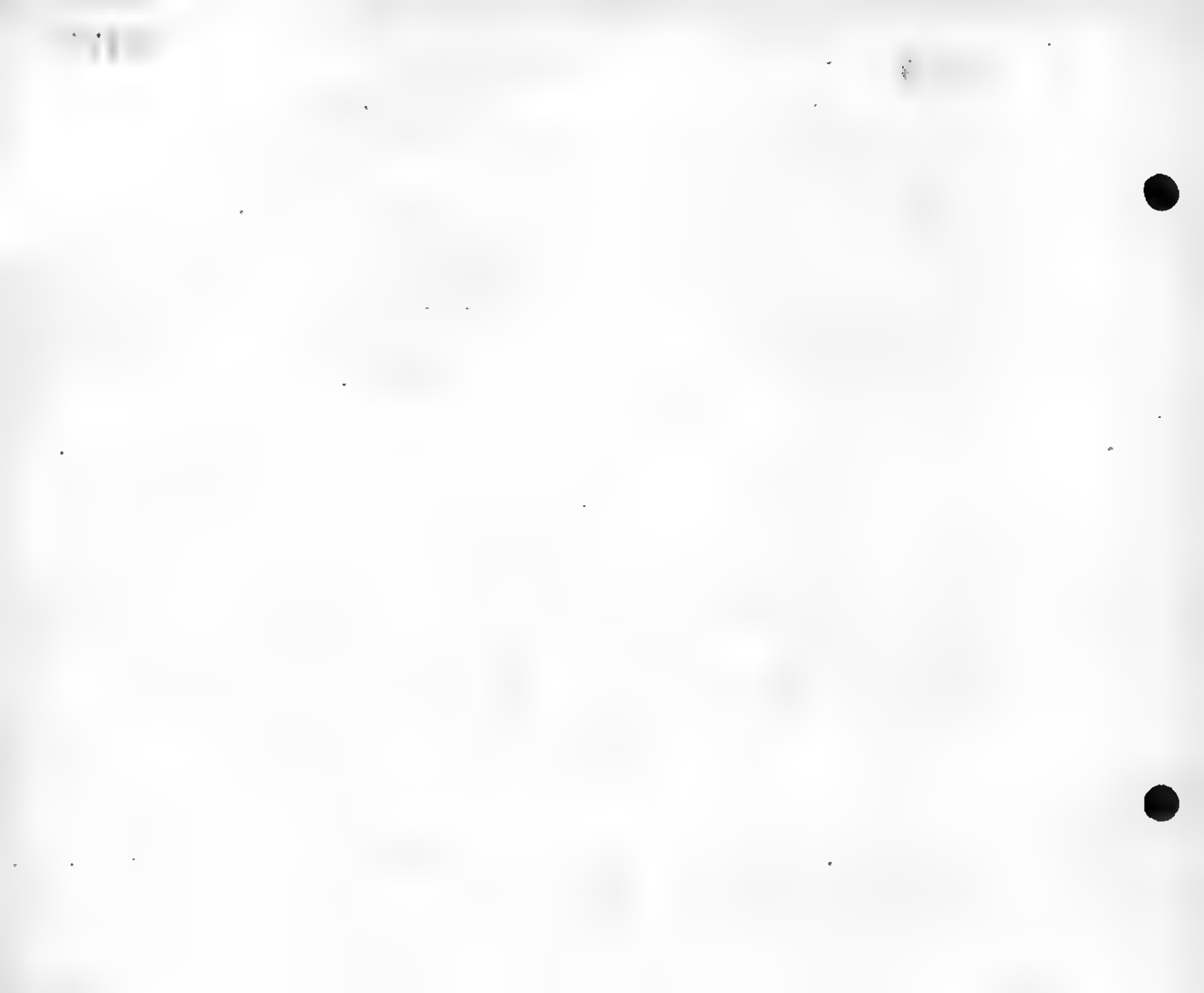


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
09193									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			c. LENGTH OF STAY IN b <b>81 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>					d. STREET ADDRESS <b>717 MARYLAND AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>SOPHIA</b> First Middle Last <b>COSGROVE</b>					4. DATE OF DEATH Month <b>JULY</b> Day <b>9</b> Year <b>66</b>				
5 SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>3-17-1885</b>		9. AGE (In years last birthday) <b>81</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11 BIRTHPLACE (County & State or foreign country) <b>Cumberland, Md.</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HENRY SCHALDT</b>					14. MOTHER'S MAIDEN NAME <b>UNKNOWN MARY CATHERINE TOTTIG</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO.		17 INFORMANT Address <b>Mrs. Josephine Hardy, Cumberland, Md.</b>				
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7/5</b> , 19 <b>66</b> , to <b>7/9</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/9</b> , 19 <b>66</b> , and that death occurred at <b>9:05 PM</b> causes and on the date stated above.									
22a. SIGNATURE <b>Leo H. Ley, Jr.</b>					M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>7/12/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>DR. LEO H LEY</b>					22d. ADDRESS <b>456 N CENTRE ST. CUMBERLAND, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>July 12, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. - Allegany</b>			
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>					25a. REC'D BY REGISTRAR DATE <b>JUL 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





09200

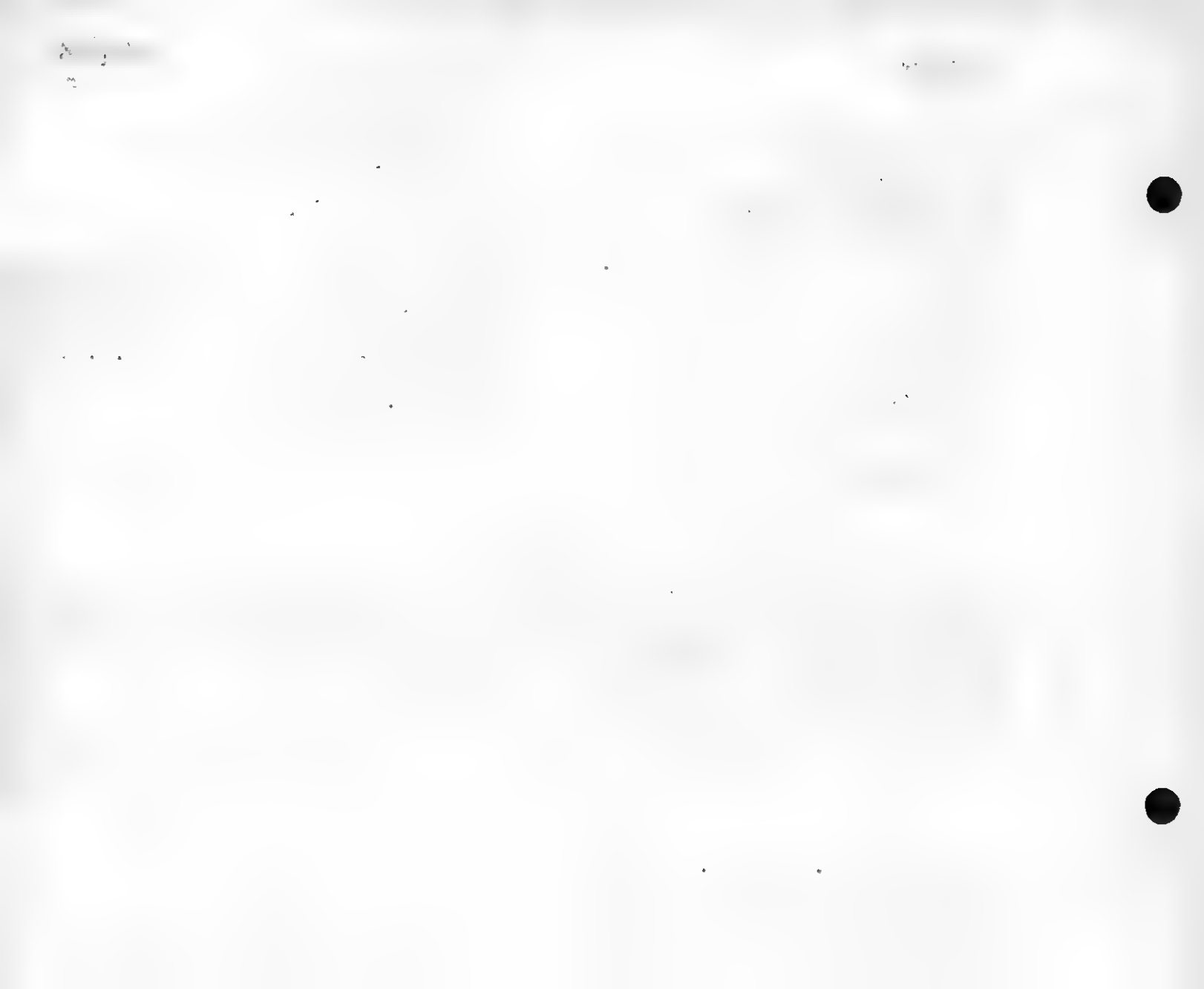
## CERTIFICATE OF DEATH

09192

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>59 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>433 RACE ST.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>GROVER C. COX</b>		4 DATE OF DEATH Month Day Year <b>JULY 3 1966</b>	
5. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>MARCH 7, 1885</b>
9 AGE (In years last birthday) <b>81</b>		10 IF UNDER 1 YEAR Months Days Hours Min	
11 BIRTHPLACE (County & State, or foreign country) <b>MARYLAND-Nevada, Mo.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELI COX</b>		14. MOTHER'S MAIDEN NAME <b>ANNA M. SHAW</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocarditis &amp; Decongestion</b> DUE TO (c) <b>Enterocolitis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b> <b>3 min</b> <b>5 yrs</b>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1, 1966</b> to <b>July 3, 1966</b> that (I) (we) last saw the deceased alive on <b>July 2, 1966</b> and that death occurred at <b>9:10 P.M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Clay E. Durrett</b>		22b. DATE SIGNED <b>7/5/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. CLAY E. DURRETT</b>		22d. ADDRESS <b>236 VIRGINIA AVE. CUMB.MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <b>July 6, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>
24 FUNERAL DIRECTOR <b>James F. Scarnelli, Cumlerland, Md.</b>		25a REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages (and) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09193

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>23 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. STREET ADDRESS <b>610 Louisiana Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>M.</b> Last <b>Diehl</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 12, 1897</b>
9. AGE (In years, last birthday) yrs <b>68</b>		10. FUNDUS 1 YEAR Months <b>4</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reuben A. Brown</b>		14. MOTHER'S MAIDEN NAME <b>May (Harbaugh) Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Glenn W. Diehl</b>		Address <b>610 Louisiana Ave Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>4201</b> IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>CORONARY SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>-----</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN DEATH AND EXAMINATION <b>-----</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 4, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 7, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>
24. FUNERAL DIRECTOR <b>William G. Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

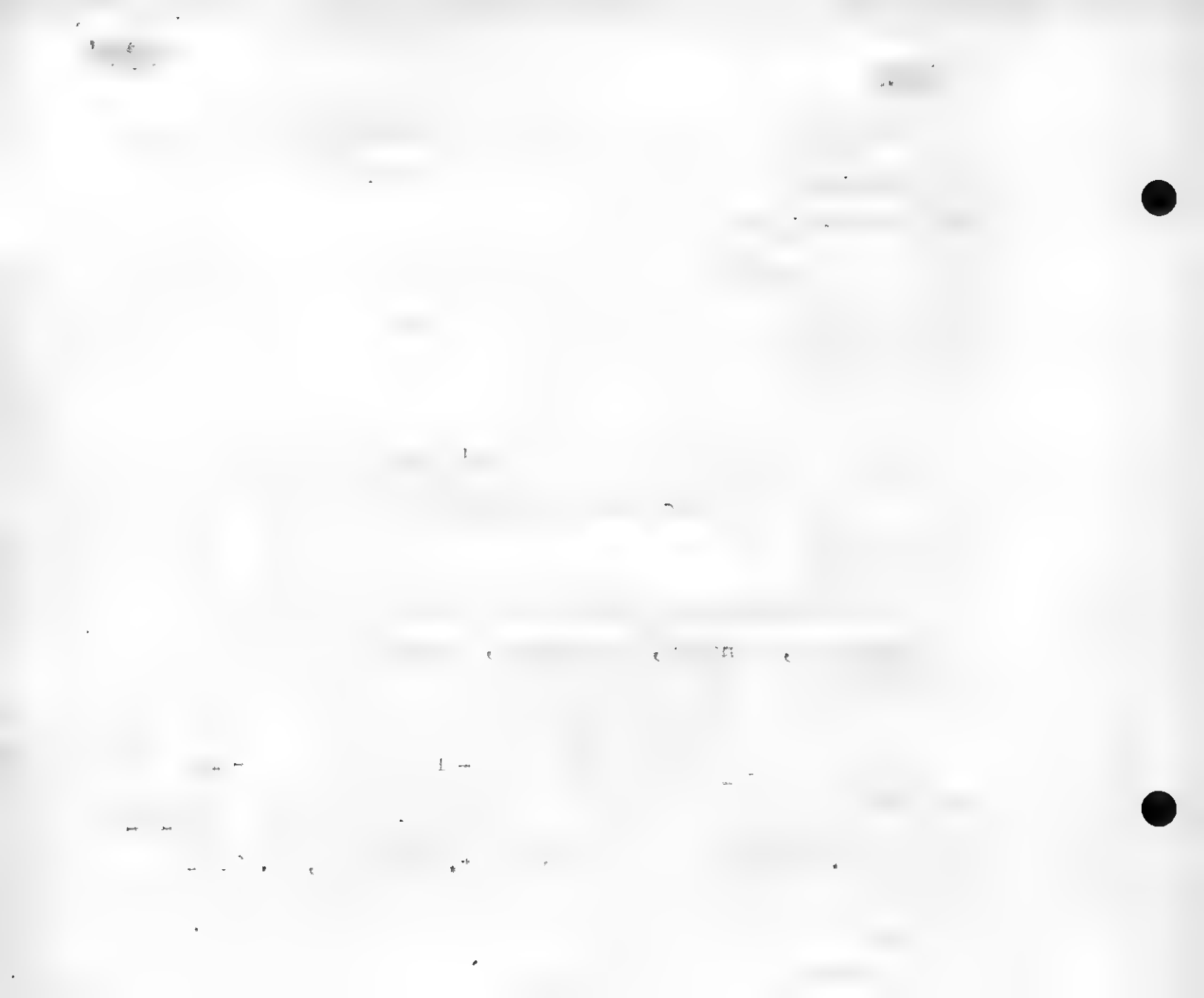
09202

09194

1 PLACE OF DEATH a COUNTY <b>ALLEGANY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>CUMBERLAND</b>		c LENGTH OF STAY IN 1b <b>6 HRS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>HARVEY DIETLE</b>		4. DATE OF DEATH <b>7/14/66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/97</b>
9. AGE (In years last birthday) <b>68</b> YRS		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired roads worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Roads Dept.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Greenville Twp. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Deitle</b>		14. MOTHER'S MAIDEN NAME <b>Christian Nedro</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>217-28-9500</b>	
17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Tuberculosis, pulmonary, far advanced, active</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>7 - 11</b> , 19 <b>66</b> , to <b>7 - 14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7 - 14</b> , 19 <b>66</b> , and that death occurred at <b>8 p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Loyle W. Ballin</b>		22b. DATE SIGNED <b>7-15-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. BALLIN</b>		22d. ADDRESS <b>62 Greens St. Cumberland, Md. 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/17/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Grantsville</b>	23d. LOCATION (City or Town) (County) (State) <b>Grantsville, Garrett Co. Md.</b>
24. FUNERAL DIRECTOR <b>Don Newman</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>JUL 20 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of body in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

09195

CS203

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> COUNTY <b>ALLEGANY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c LENGTH OF STAY IN 1b <b>4 Days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FLINTSTONE</b>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>DAYTON</b> Middle <b>D.</b> Last <b>DOLLY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>66</b>	
5 SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B DATE OF BIRTH <b>NOV. 12, 1894</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	9 AGE (In years last birthday) <b>71</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSIAH DOLLY (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA MALLOW DOLLY (DECEASED)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO <b>212118-1374</b>	
17 INFORMANT <b>PATIENT'S CH ART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Rectal Bleeding due to diverticulitis of colon</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-30</b> , 19 <b>66</b> , to <b>7-4</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>7-4</b> , 19 <b>66</b> , and that death occurred at <b>3:45</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wayne C. Spiggle</b>		22b. DATE SIGNED <b>7/6/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wayne C. Spiggle, M.D.</b>		22d. ADDRESS <b>126 N. Smallwood St. Cumberland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>7/7/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Glendale Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Flintstone Allegany Md.</b>
24 FUNERAL DIRECTOR <b>William G. Kight</b>		25a REC'D BY REGISTRAR DATE <b>JUL 8 1966</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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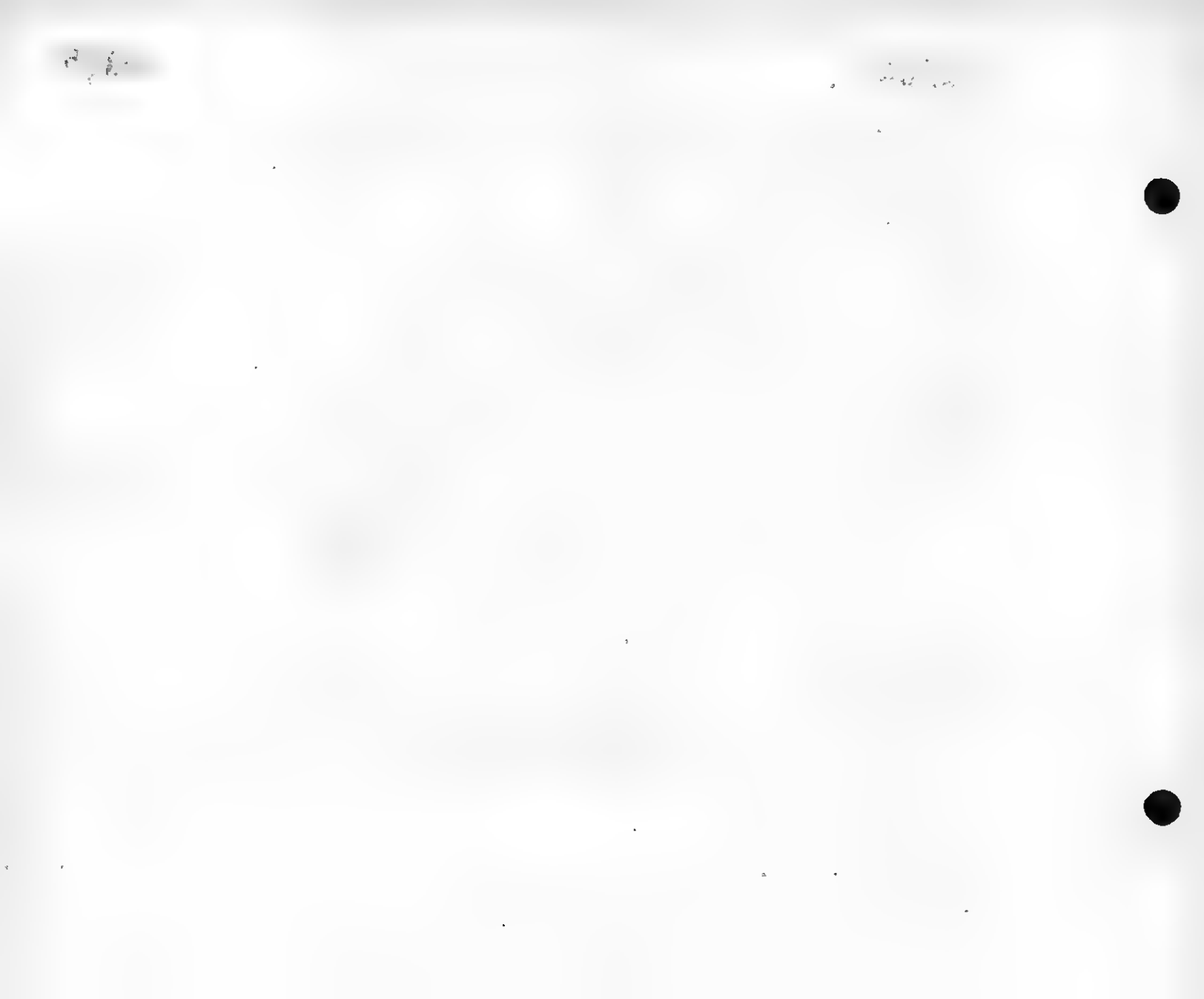
## CERTIFICATE OF DEATH

09196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>607 ELM ST.</b>	
3. NAME OF DECEASED (Type or print) <b>MR. JOHN R DORN</b>		4. DATE OF DEATH <b>JULY 23 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/93</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Crystal Landings</b>	9. AGE (in years) <b>72</b> (months) <b>72</b> (days) <b>72</b> (hours) <b>72</b> (minutes) <b>72</b>
11. BIRTHPLACE (County & State or foreign country) <b>Cumberland Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN L DORN</b>		14. MOTHER'S MAIDEN NAME <b>IRENE LITTLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-7029</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>type</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cardiovascular Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 1966</b> to <b>July 23, 1966</b> , that (I) (we) last saw the deceased alive on <b>July 23, 1966</b> and that death occurred at <b>7:07 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>G.O. Himmelwright</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/25/66</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. G.O. HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Ph. Cumberland Md.</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md.</b>
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>		25a. REC'D BY REGISTRAR <b>Cumb. Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 28 1966</b>	



09205

CERTIFICATE OF DEATH

09197

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>MT. SAVAGE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>E</b> Last <b>EMERICK</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>24</b> Year <b>66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-19-1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Allegany Coal Garage</b>	9. AGE (In years last birthday) <b>58</b> yrs
11. BIRTHPLACE (County & State, or foreign country) <b>Allegany Co.-Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>JOHN EMERICK</b>		14. MOTHER'S MAIDEN NAME <b>CLARA KENNEL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>218-07-6766</b>	
17. INFORMANT <b>Leo Edward Emerick, U S Navy, Norfolk, Va</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO (b) <b>metastatic carcinoma (Terminal)</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-23</b> , 19 <b>66</b> , to <b>7-24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>4:13 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Vicente M. Valls</b>		22b. DATE SIGNED <b>7/27/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. VICENTE VALLS</b>		22d. ADDRESS <b>133-A S CENTRE ST. CUMBERLAND, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>La Vale Allegany Co. Md</b>
24. FUNERAL DIRECTOR <b>John F. Hefner - Cumberland</b>		25a. REC'D BY REGISTRAR <b>John F. Hefner</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 29 1966</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09206

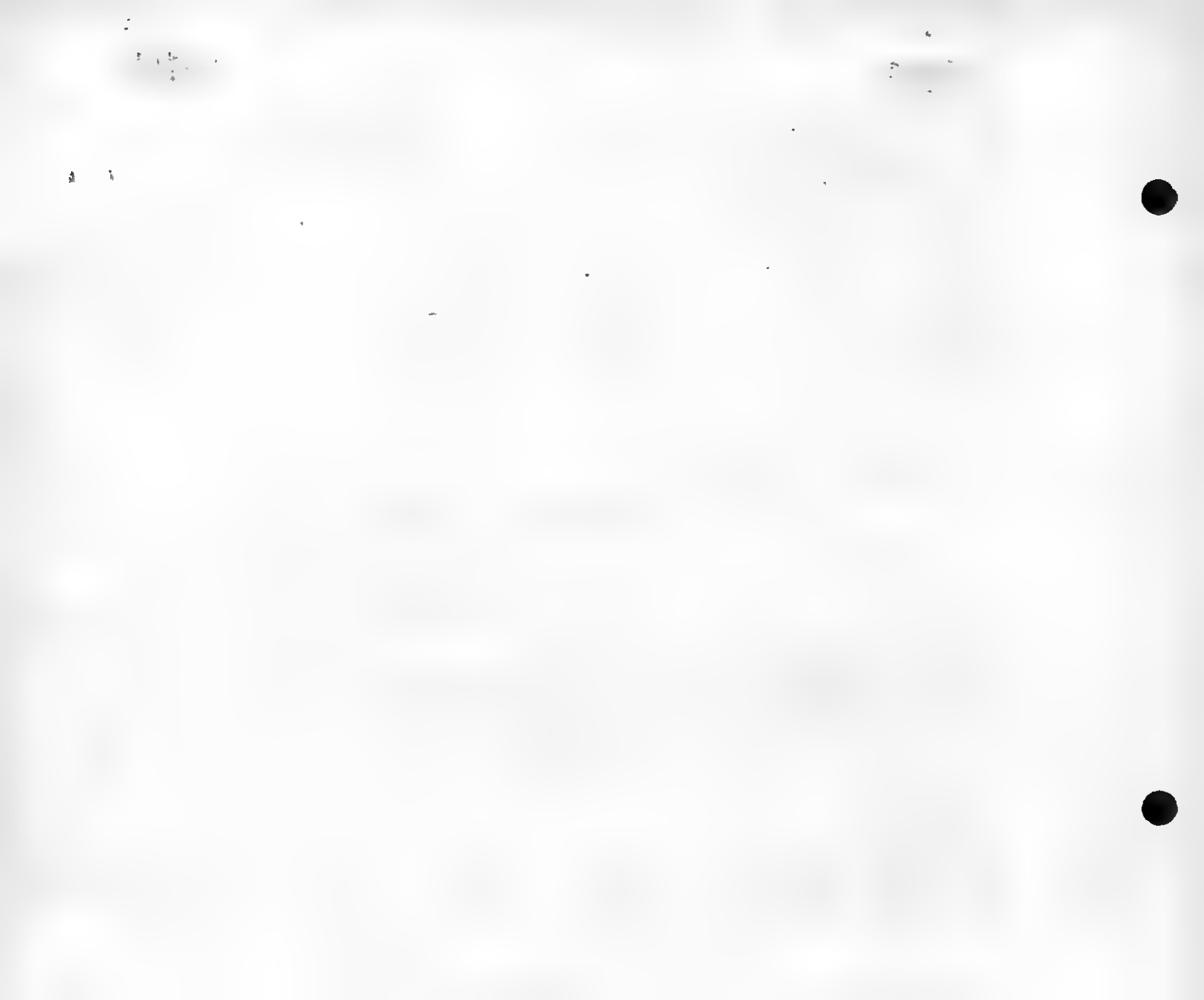
## CERTIFICATE OF DEATH

09198

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>10 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>409 WINNER ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>E.</b> Last <b>EMERICK</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>FEMALE</b>	6. CO. OR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5 -26-16</b>
9. AGE (In years last birthday) yrs <b>50</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR IND. STRY <b>Own Home</b>	
11. BIRTHPLACE (County & State or foreign country) <b>allerslie, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN FORMAN</b>		14. MOTHER'S MAIDEN NAME <b>EDDA (SMITH) FORMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1753</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fan adenoma probably</b> DUE TO (c) <b>Ovarian carcinoma</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) lost saw the deceased alive on <b>7-14</b> 19 <b>66</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Carlton Brinsfield</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>CARLTON BRINSFIELD MD</b>		22d. ADDRESS <b>401 Decatur St.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 17, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bedford Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bedford, Pa.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 20 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





09199

## CERTIFICATE OF DEATH

09207

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>53 years</b>	
d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) <b>131 Oak Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Solomon</b> Middle <b>Le Roy</b> Last <b>Goodrich</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. CO. OR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 22, 1895</b>
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	9. AGE (In years last birthday) yrs <b>71</b>
11. BIRTHPLACE (County & State or foreign country) <b>Ocean, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph L. Goodrich</b>		14. MOTHER'S MAIDEN NAME <b>Fannie F. Long</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Martha Goodrich, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201 Acute Myocardial Infarction, probable</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/7/65</b> , 19____, to <b>5/18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>5/18</b> , 19 <b>66</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>L M Glick</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Michael Glick, M.D.</b>		22d. ADDRESS <b>126 N. Smallwood St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>July 13, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CS208

## CERTIFICATE OF DEATH

09200

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegheny</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN 1b <u>87 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>406 Prince George Street</u>		d. STREET ADDRESS <u>406 Prince George St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Henry Griffin</u>		4. DATE OF DEATH Month Day Year <u>July 23 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1879</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Retired Grocer/Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John T. Griffin</u>		14. MOTHER'S MAIDEN NAME <u>Laura Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>George A. Griffin, Cumberland, Md.</u>	
17. INFORMANT Address <u>George A. Griffin, Cumberland, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1966</u> to <u>July 1966</u> that (I) (we) last saw the deceased alive on <u>July 2 1966</u> , and that death occurred at <u>7:24 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Blane M. Schindler</u>		22b. DATE SIGNED <u>7-24-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Blane M. Schindler, M.D.</u>		22d. ADDRESS <u>43 Greene St., Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 25, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Md. Allegheny</u>
24. FUNERAL DIRECTOR <u>James F. Scarnelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 27 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>James F. Scarnelli</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Loge & my be retained by the individual as long as

**Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and prevent, within 72 hours after death.

VR A15 (4)  
20 M 1/66



09203

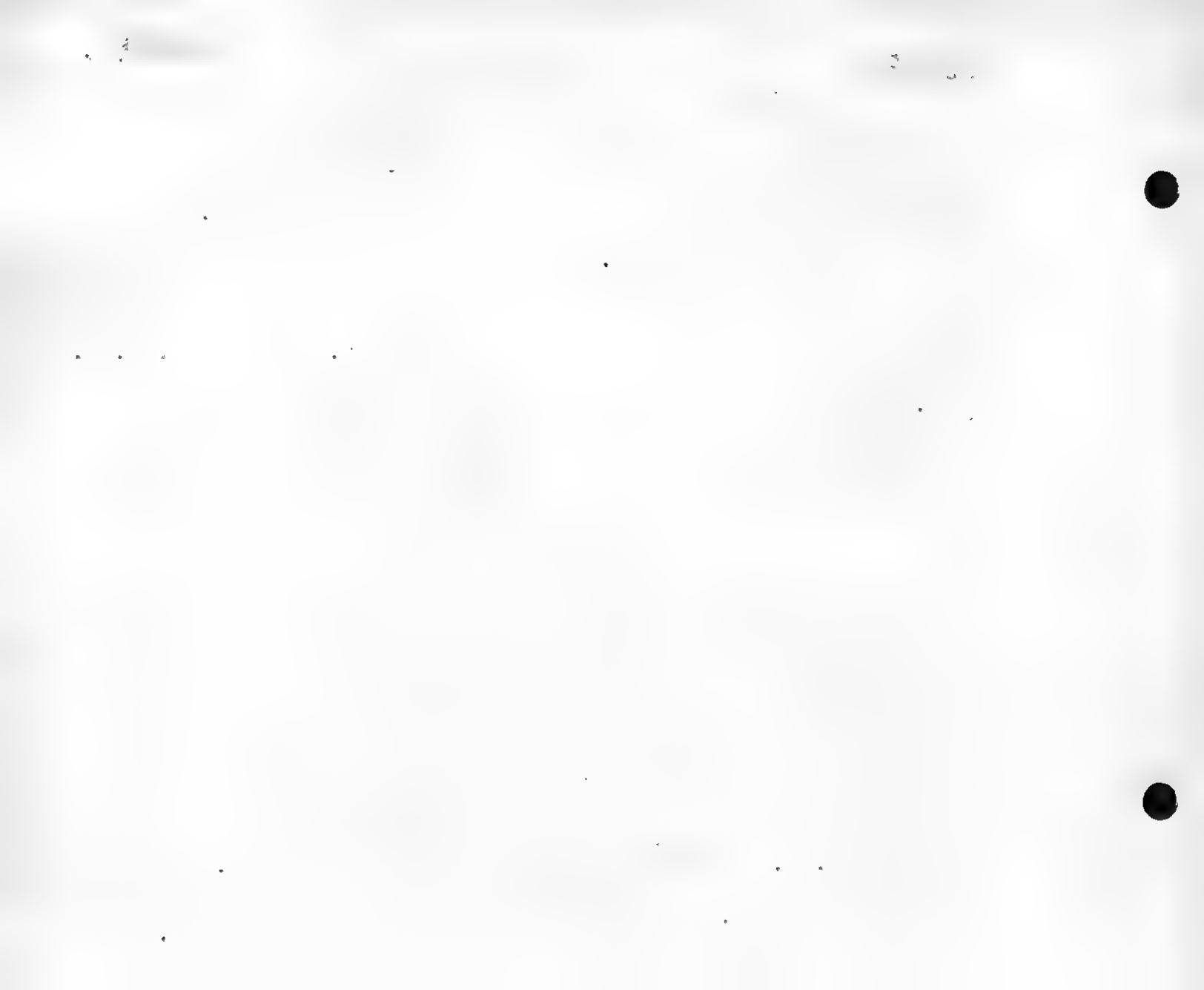
## CERTIFICATE OF DEATH

09201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c LENGTH OF STAY IN lb <b>16 DAYS</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAVALE</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d STREET ADDRESS <b>106 SANTE FE ST.</b>	
3 NAME OF DECEASED (Type or print) First <b>ZILLAH</b> Middle <b>J.</b> Last <b>HABEL</b>		4 DATE OF DEATH Month <b>JULY</b> Day <b>30</b> Year <b>1966</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-5-1888</b>
9. AGE (In years last birthday) yrs <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <b>FAYETTE CO. PA.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>J. GIBBONS</b>	
14. MOTHER'S MAIDEN NAME <b>CORA ASPINWAL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16 SOCIAL SECURITY NO.		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Adenocarcinoma Sigmoid</i> DUE TO (b) <i>Colon</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>11 Mo</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>As Seen Sigmoid Cancer Vasculu Arterio</i>			19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1954</b> to <b>1966</b> , that (I) (we) last saw the deceased alive on <b>July 27, 1966</b> and that death occurred at <b>5:50 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. G. Overton Himmelwright</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/31/66</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>		22d. ADDRESS <b>CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 1, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland, Allegany</b>
24. FUNERAL DIRECTOR <b>John J. Haffer</b>		25a. REC'D BY REGISTRAR <b>John J. Haffer</b>	25b. REGISTERED BY <b>Charles Jones</b>



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

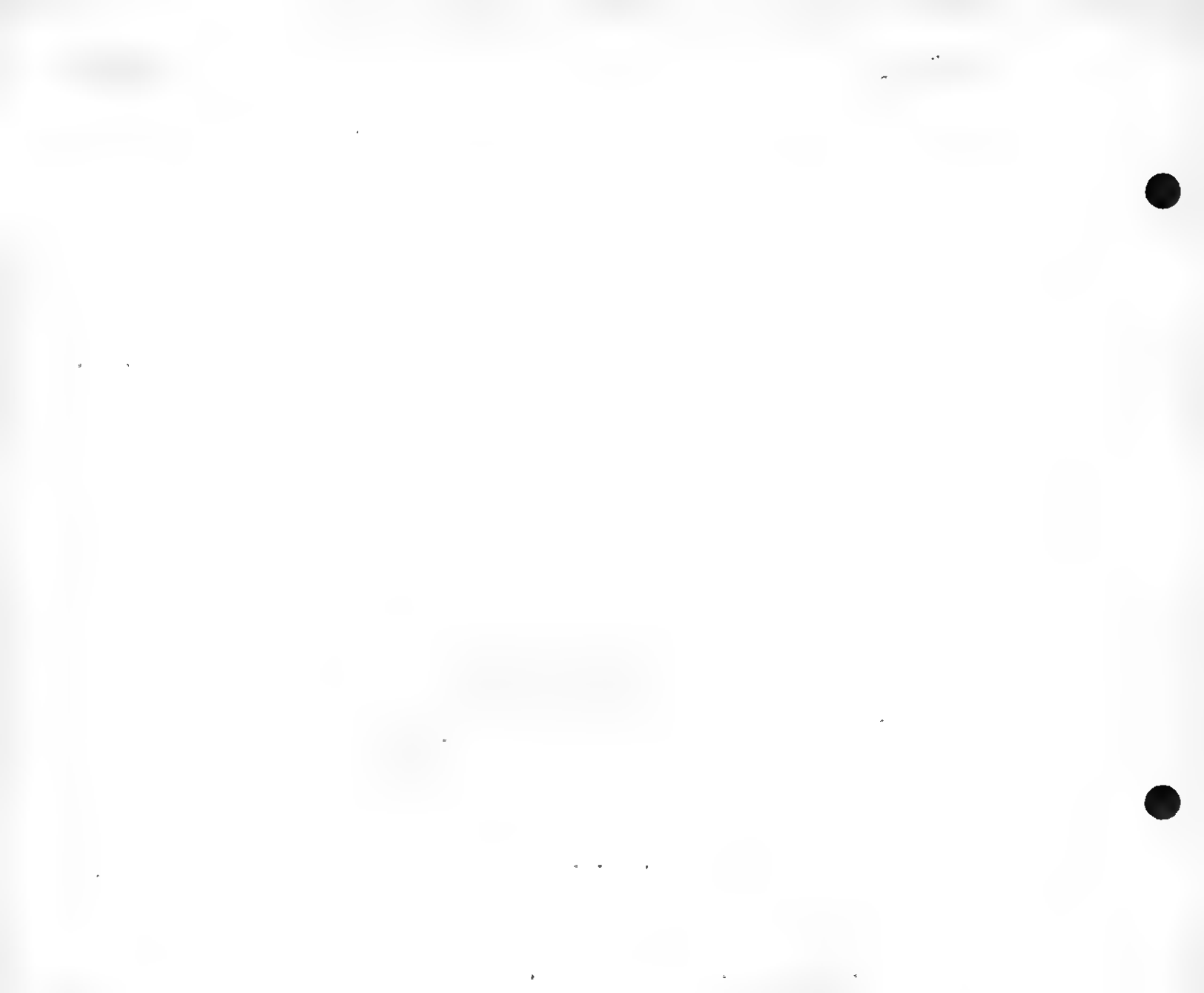
09210

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09202

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>ALLEGANY</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>CUMBERLAND</b>		c LENGTH OF STAY IN 1b <b>1 HR.</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(ECKHART) FROSTBURG, MD.</b>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL HOSPITAL</b>				d STREET ADDRESS <b>ROUTE 1</b>			
3 NAME OF DECEASED (Type or print) First <b>HUEY</b> Middle <b>LONG</b> Last <b>HAMRICK</b>				4 DATE OF DEATH Month <b>JULY</b> Day <b>22</b> , Year <b>1966</b>			
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DEC. 29, 1958</b>	9 AGE (in years last birthday) <b>7</b> yrs	10 IF UNDER 1 YEAR Months Days Hours Min		11 IF UNDER 24 HRS. Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>		11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>HUEY L. HAMRICK</b>				14 MOTHER'S MAIDEN NAME <b>SHEILA LANCASTER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE</b>		16 SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT <b>MRS. SHEILA HAMRICK, RT. 1, FROSTBURG, MD.</b>			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage, Massive</b> DUE TO <b>Skull Fracture</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 Hours</b> <b>2 Hours</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by Automobile</b>					
20c TIME OF INJURY Month, Day, Year <b>7:45 pm July 22 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Piney Mt. Road</b>		20f (City or town) (County) (State) <b>Eckhart, Allegany, Maryland</b>	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>July 22, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>7-25-66</b>		23c NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>		23d LOCATION (City or Town) (County) (State) <b>ECKHART, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>				25a REC'D BY REGISTRAR DATE <b>JUL 27 1966</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





## CERTIFICATE OF DEATH

09203

09211

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN TB <b>4 Years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>613 Lynn Street</b>		e. STREET ADDRESS <b>613 Lynn Street</b>	
3 NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Walter</b> Last <b>Harris</b>		4 DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1891</b>
9. AGE (In years last birthday) <b>75 yrs</b>		10. IF UNDER 1 YEAR Months <b>1</b> Year <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <b>Retired Silk Mill Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lonoconing Alleg Co Md</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Harris</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Prichard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-10-1445</b>	
17. INFORMANT <b>Mrs. Stella Harris</b>		Address <b>613 Lynn Street Cumberland, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebro-vascular accidents, multiple</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive ACVD</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>5 years</b>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11 - 16</b> , 19 <b>53</b> to <b>7 - 3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7 - 2</b> , 19 <b>66</b> and that death occurred at <b>3 p.m.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>7-5-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene St. Cumberland, Md 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/6/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alleg Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>JUL 7 1966</b>	
ADDRESS <b>Cumberland, Maryland 21502</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If page 3 is not to be used, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> c. LENGTH OF STAY IN 1b <b>LIFETIME</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>35 WEST COLLEGE AVENUE</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b> d. STREET ADDRESS <b>35 WEST COLLEGE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>HARTIG</b> Last <b>HARTIG</b>					4. DATE OF DEATH Month <b>JULY</b> Day <b>5</b> Year <b>19 66</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEB. 13, 1885</b>		9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR: Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OWN HOME</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>FROSTBURG, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN HARTIG</b>					14. MOTHER'S MAIDEN NAME <b>CATHERINE DILFER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. ALICE SCROGGAN, 62 W. COLLEGE AVE.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443x</b> DUE TO (b) <b>Hypertensive Cardio-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Vascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6-10</b> , 19 <b>66</b> , to <b>7-5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-1</b> , 19 <b>66</b> , and that death occurred at <b>7-5</b> A.M., from the causes and on the date stated above.									
22a. SIGNATURE <b>H.C. Diehl</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>7/7/66</b>				
22c. PHYSICIAN'S NAME (Type) <b>H.C. DIEHL, M.D.</b>					22d. ADDRESS <b>39 W. MAIN ST., FROSTBURG, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>JULY 8, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FROSTBURG MEM. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FROSTBURG MARYLAND</b>		
24. FUNERAL DIRECTOR <b>MARILOU SOWERS</b>			25a. REC'D BY REGISTRAR <b>JUL 12 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



09213

## CERTIFICATE OF DEATH

09205

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
c. LENGTH OF STAY IN 1b <b>2/20/1945</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>HENRY STREET</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>James Hillry Hayden</b>		4 DATE OF DEATH Month Day Year <b>July 21, 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>3/31/1877</b>
9 AGE (n years last birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired: Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Charles T. Hayden</b>		14. MOTHER'S MAIDEN NAME <b>Helen May Ferguson</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates at service) <b>NO</b>		16 SOCIAL SECURITY NO <b>220 10 9366</b>	
17 INFORMANT P.O.Box 599, Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary records.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis, Ch. degeneration, Senile</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arterio-Sclerosis, General, Senile</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/20/1945</b> , 19__ to <b>7/21/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>7/21/66</b> , 19__, and that death occurred at <b>P. M.</b> , from causes and on the date stated above. at <b>7:35 P.M.</b>			
22a. SIGNATURE <b>Lee B. Mathews, M. D.</b>		22b. DATE SIGNED <b>7/22/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 25, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md.</b>
24. FUNERAL DIRECTOR <b>Byron Knight</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 26 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



09214

CERTIFICATE OF DEATH

09206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. Any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>112 HENRY ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WANDA</b> Middle <b>B</b> Last <b>HILLEARY</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>10</b> Year <b>1966</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-1913</b>	9. AGE (In years last birthday) <b>52</b> yrs.	F UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>ROBERT T. METZ</b>				14. MOTHER'S MAIDEN NAME <b>IVY M. BROOKS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-8719</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral infarction</b> DUE TO <b>Stroke</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Unusual</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1966</b> to <b>July 9, 1966</b> that (I) (we) last saw the deceased alive on <b>July 9, 1966</b> and that death occurred at <b>4:40 PM</b> from causes and on the date stated above.							
22a. SIGNATURE <b>B. Schindler</b>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>7/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. SCHINDLER</b>				22d. ADDRESS <b>43 GREENE ST.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/13/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mems. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md</b>	
24. FUNERAL DIRECTOR <b>Louis Stein Inc.</b>				ADDRESS <b>Cumb. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 13 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

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M  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09215

09207

1 PLACE OF DEATH a COUNTY <b>ALLEGANY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a STATE <b>MARYLAND</b> b COUNTY <b>ALLEGANY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c LENGTH OF STAY IN TB <b>33 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>F.</b> Last <b>HOSKEN</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>3</b> Year <b>19 66</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>SEPT. 10, 1882</b>
9 AGE (In years) <b>83</b> Months Days Hours Min		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>JOHN FARRADY</b>	
14 MOTHER'S MARDEN NAME <b>MARGARET FREAL</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NONE</b>	
16 SOCIAL SECURITY NO. <b>NONE</b>		17 INFORMANT <b>MRS. GRACE DENSMORE, CATONSVILLE, MD.</b>	
18. CAUSE OF DEATH (Enter any one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM, MASSIVE</b> DUE TO (b) <b>FRACTURE OF RIGHT HIP</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>34 Days</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTENSAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>FELL AT HOOME</b>	
20c TIME OF INJURY Month Day, Year <b>3:30 p.m. JULY 3 19 66</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (home farm factory, street, office bldg, etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Frostburg, Alleg. Maryland</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>JULY 3, 1966</b> Address (Street, city, town, or county) <b>CUMBERLAND, MD.</b>	
23a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>JULY 6, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>	23d LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24 FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a REC'D BY REGISTRAR DATE <b>JUL 8 1966</b>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09208

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALFRED</b> Middle <b>HUNTER</b> Last <b>HUNTER</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>7th</b> Year <b>19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 14th, 1888</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>66</b> Min	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>
10a. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. ELEC. MAINT. MAN</b>		10b. K. N.D. OF BUSINESS OR INDUSTRY <b>COAL MINES</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>GEORGE HUNTER</b>	
14. MOTHER'S MAIDEN NAME <b>MARY LOGSDON</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO <b>214-01-3801</b>		17. INFORMANT <b>MRS. MARY HUNTER, MESHACK FROST VILLAGE, F.B.G., MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary Sclerosis</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>7</b> <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>July 5, 1966</b> to <b>July 7, 1966</b> that (I) (we) last saw the deceased alive on <b>July 5, 1966</b> , and that death occurred <b>7:04 PM</b> from causes and on the date stated above.	
22a. SIGNATURE <b>W. O. McLane</b>		22b. DATE SIGNED <b>July 8, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. O. McLane,</b>		22d. ADDRESS <b>167 E. MAIN STREET, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>7-9-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK</b>		23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.</b>		25a. REC'D BY REGISTRAR <b>FROSTBURG, MD.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JUL 12 1966</b>	



# MARYLAND-STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

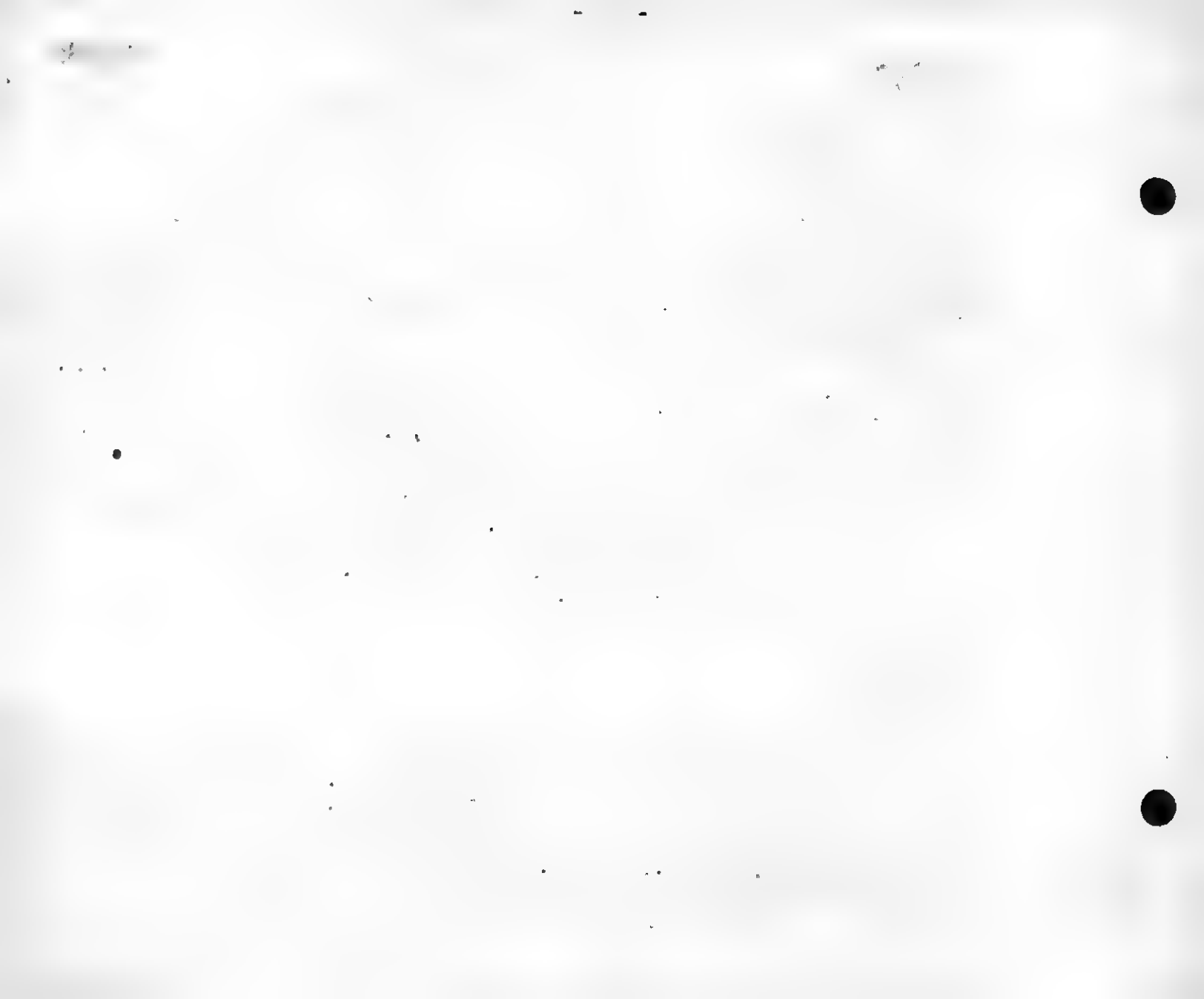
09217

09209

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/26/1966</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>528 Cumberland Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Barbara</b> Middle <b>Janicki</b> Last <b>Janicki</b>		4. DATE OF DEATH Month <b>July</b> Day <b>4</b> Year <b>66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1876</b>
9. AGE (In years last birthday) <b>89</b> yrs		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. FATHER'S NAME <b>Christopher Drieze</b>		16. MOTHER'S MAIDEN NAME <b>Elizabeth Seymour</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18. SOCIAL SECURITY NO <b>Allegany County Infirmary records.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the Pelvis &amp; Vaginal atre-</b> <b>1966</b> DUE TO <b>Tumor of the Rt. Breast, possible Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Myocarditis, Chr. Degenerative.</b> DUE TO <b>Arteriosclerosis, General. Residuals</b> (c) <b>of Polio, Rt. Leg Atrophy.</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/26/66</b> , 19____, to <b>7/4/66</b> , 19____, that (I) (we) last saw the deceased alive on <b>7/2/66</b> , 19____, and that death occurred at <b>P. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Lee B. Mathews, M. D.</b>		22b. DATE SIGNED <b>7/5/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memo Ph</b>	23d. LOCATION (City or Town) (County) (State) <b>Frostburg Md</b>
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumber, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

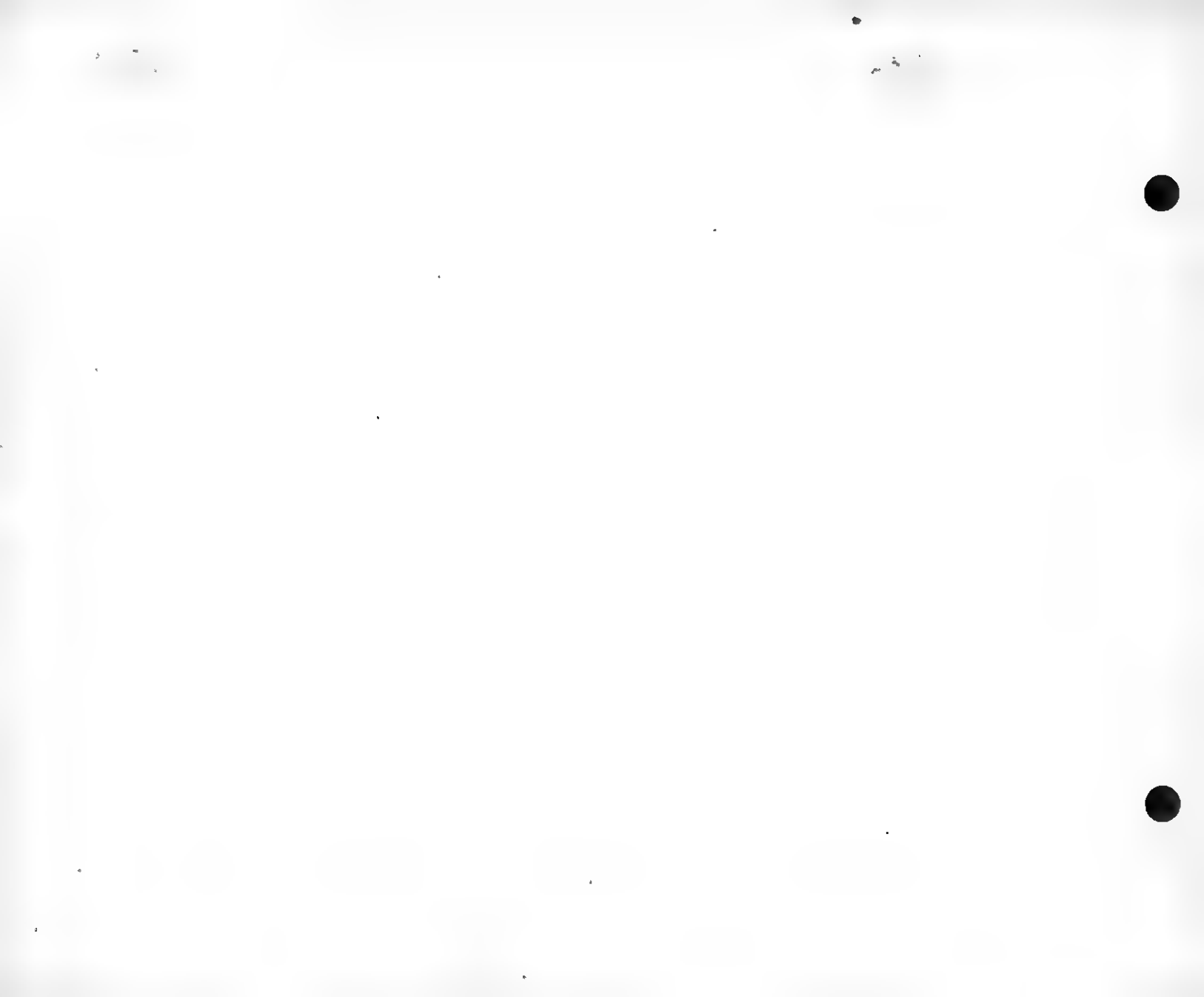
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09218

09210

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if not list on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) <u>Cresaptown, Box # 236</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Sacred Heart Hosp. -DOA</u>			d. STREET ADDRESS <u>McMullen Hwy.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Andrew</u> Last <u>Judy</u>			4 DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1966</u>		
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 23, 1877</u>	9 AGE (in years last birthday) <u>89</u> yrs	IF UNDER 1 YEAR Months <u>0</u> Days <u>19</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Fibres Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Lewisburg, W. Va.</u>	
13 FATHER'S NAME <u>Allen Judy</u>			12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16 SOCIAL SECURITY NO <u>214-07-5336</u>		17 INFORMANT <u>Mrs. Bertha Anne Judy</u> Address <u>Box 236 Cresaptown, Md.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY SCLEROSIS</u> (c) <u>---</u>					INTERVAL BETWEEN ONSET AND DEATH <u>SUBTLE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part I of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Benedict Skitarellic</u>		EXAMINER'S NAME (Type) <u>Benedict Skitarellic, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Rt. # 9 Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>			25a. REC'D BY REGISTRAR DATE <u>JUL 25 1966</u>		
			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09213

09211

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN it <b>4 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>M.</b> Last <b>KELLEY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-12-1897</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret. red) <b>Signal Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DELAWARE</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN KELLEY</b>		14. MOTHER'S MAIDEN NAME <b>MARY MITCHNER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes 1912-1918</b>		16. SOCIAL SECURITY NO <b>705-09-2983</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY <b>4221</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage &amp; massive cerebral infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/18/66</b> to <b>7/22/66</b> , that (I) (we) lost saw the deceased alive on <b>7/21</b> 19 <b>66</b> , and that death occurred at <b>7/22</b> M, from causes and on the date stated above		22a. SIGNATURE <b>[Signature]</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>7/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>		22d. ADDRESS <b>59 GREENE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>July 24, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Berlin Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Berlin Somerset Co., Pa</b>
24. FUNERAL DIRECTOR <b>Harvey H. Feigler</b> ADDRESS <b>Hyndman, Pa.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
DATE <b>JUL 27 1966</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.



09220

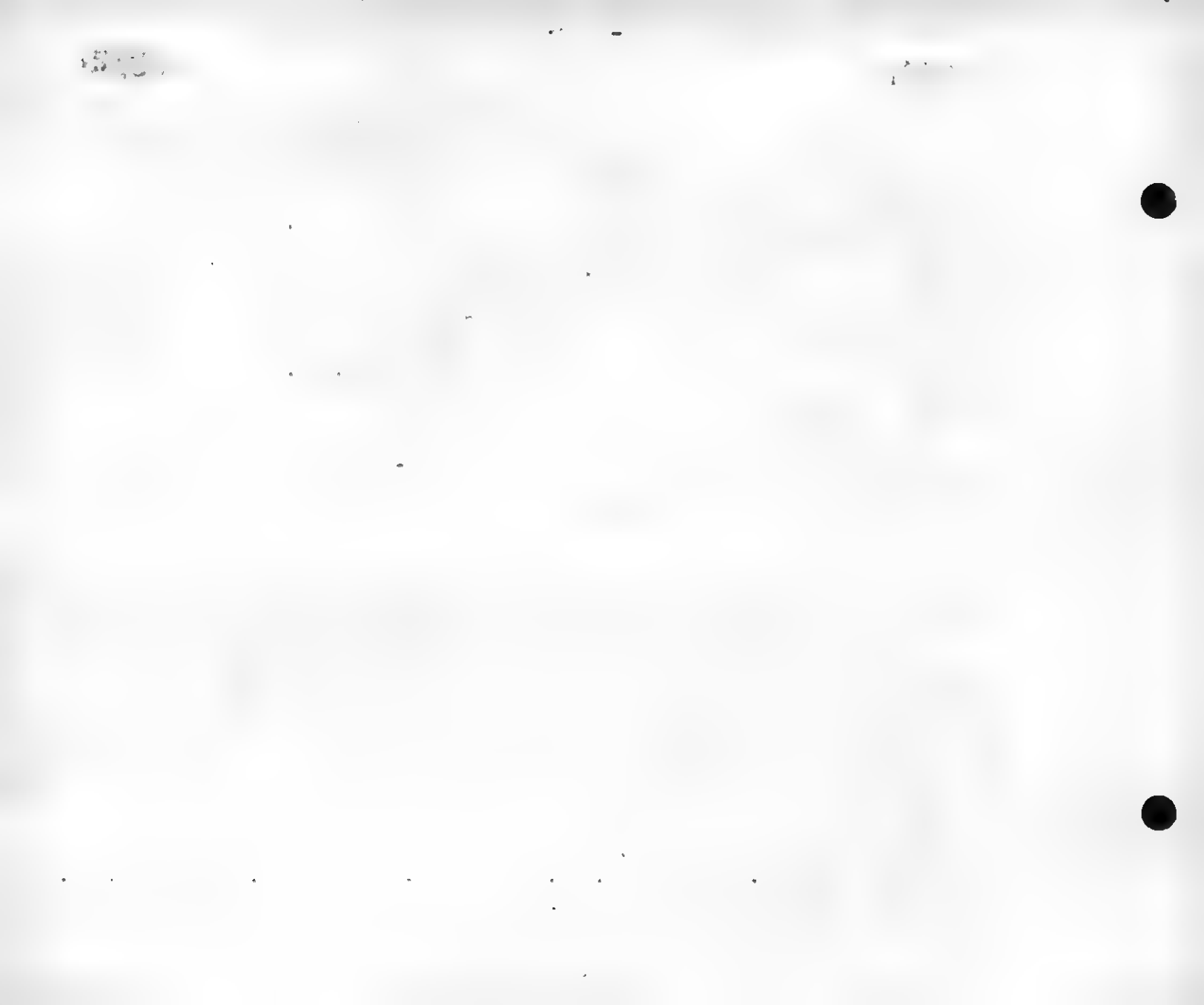
CERTIFICATE OF DEATH

09212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b> d. STREET ADDRESS <b>316 FAYETTE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>T.</b> Last <b>KELLY</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-2-97</b> 9. AGE (In years last birthday) <b>68</b> yrs IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>WESTERNPORT, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN Kelly</b>		14. MOTHER'S MAIDEN NAME <b>ELLA Footen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Aneurysm</b> DUE TO (b) <b>Cerebral Vascular Accident</b> DUE TO (c) <b>Hypertension with cerebral involvement</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1966</b> to <b>July 19, 1966</b> that (I) (we) last saw the deceased alive on <b>July 19, 1966</b> and that death occurred at <b>4:15</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Wyand F. Doerner, Jr., MD.</b>		22b. DATE SIGNED <b>7-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WYAND F. DOERNER, JR., MD.</b>		22d. ADDRESS <b>414 N. MECHANIC ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>July 8, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Ch</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Md</b>
24. FUNERAL DIRECTOR <b>Louis Stein Inc. Cumb. Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



## CERTIFICATE OF DEATH

09213

09221

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>67 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER. W.VA.</b> d. STREET ADDRESS <b>83 E. ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mattie Pauline Kosecker</b>		4 DATE OF DEATH Month Day Year <b>JULY 16 19 66</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>FEB. 17, 1909</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	9. AGE (In years last birthday) yrs. <b>57</b>
11. BIRTHPLACE (County & State or foreign country) <b>Shenandoah, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES W. STANLEY</b>		14. MOTHER'S MAIDEN NAME <b>ARMINTA MEADOWS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Cerebral Thrombosis since 5/16/66</b> DUE TO (c) <b>Cerebral Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19__		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumbersville, Va.</b>
20f. City or town <b>Cumbersville, Va.</b>		20g. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/16/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>7/16/66</b> , and that death occurred on <b>7/16/66</b> from causes and on the date stated above.			
22a. SIGNATURE <b>DR. R. J. WILLIAMS</b>		22b. DATE SIGNED <b>7/16/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. R. J. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST. CUMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-19-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Keyser, W. Va. Mineral</b>	
24. FUNERAL DIRECTOR <b>Thomas Smith Jr.</b>		25a. REC'D BY REGISTRAR <b>Keyser, W. Va.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUL 18 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

09214

09222

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>W. VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>273 S. MAIN ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>EVERS</b> Middle <b>T.</b> Last <b>KESSEL</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-15-1891</b>
9. AGE (In years last birthday) <b>74</b>		10. F UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rt. Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O RR</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>FELIX KESSEL</b>		14. MOTHER'S MAIDEN NAME <b>DORY SHAFFER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-09-7129</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO (b) <b>Arteriosclerotic C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7-21</b>		20f. (City or town) (County) (State) <b>66 7-26, 1966</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>7-21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-26</b> , 19 <b>66</b> , and that death occurred at <b>8:40 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Williams</b> M.D.		22b. DATE SIGNED <b>7-27-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. W. F. WILLIAMS</b>		22d. ADDRESS <b>122 S. CENTRE ST.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jul. 29, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lahmansville Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Lahmansville, W. Va.</b>	
24. FUNERAL DIRECTOR <b>Allen H. Rotruck</b>		ADDRESS <b>Keyser, W. Va.</b>	
25a. REC'D BY REGISTRAR <b>AUG 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





09223

## CERTIFICATE OF DEATH

09215

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>226 WILLIAMS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>ANNA MARY KETZNER</b>		4 DATE OF DEATH Month <b>JULY</b>		Day <b>13</b>	
5. SEX <b>FEMALE</b>		6 COLOR OR RACE <b>WHITE</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-3-91</b>		9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months <b>5</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Harpers Ferry, W.VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN KETZNER (D)</b>	
14 MOTHER'S MAIDEN NAME <b>GEORGIANNA (FORNEY) KETZNER (D)</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17 INFORMANT <b>Mrs. Donald L. Kniel</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis</b> DUE TO <b>Myocardial Infarction</b> (b) <b>Intermittent</b> DUE TO <b>Intermittent</b> (c) <b>Intermittent</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 hrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>4:00 p.m.</b> , 19 <b>66</b> , to <b>July 13, 1966</b> , that (I) (we) lost saw the deceased alive on <b>July 13, 1966</b> , and that death occurred at <b>7:15 p.m.</b> from causes and on the date stated above	
22a. SIGNATURE <b>Clayton Durrett</b>		22b. DATE SIGNED <b>7/14/66</b>		22c. PHYSICIAN'S NAME (Type) <b>DR. DURRETT, M.B.</b>	
22d. ADDRESS <b>236 VIRGINIA AVE CUMBERLAND, MD.</b>		23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/15/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>		24 FUNERAL DIRECTOR <b>H. Wayne George</b>	
25a. REC'D BY REGISTRAR DATE - <b>JUL 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. James</b>		25c. REGISTRAR'S NAME <b>J. James</b>	



09224

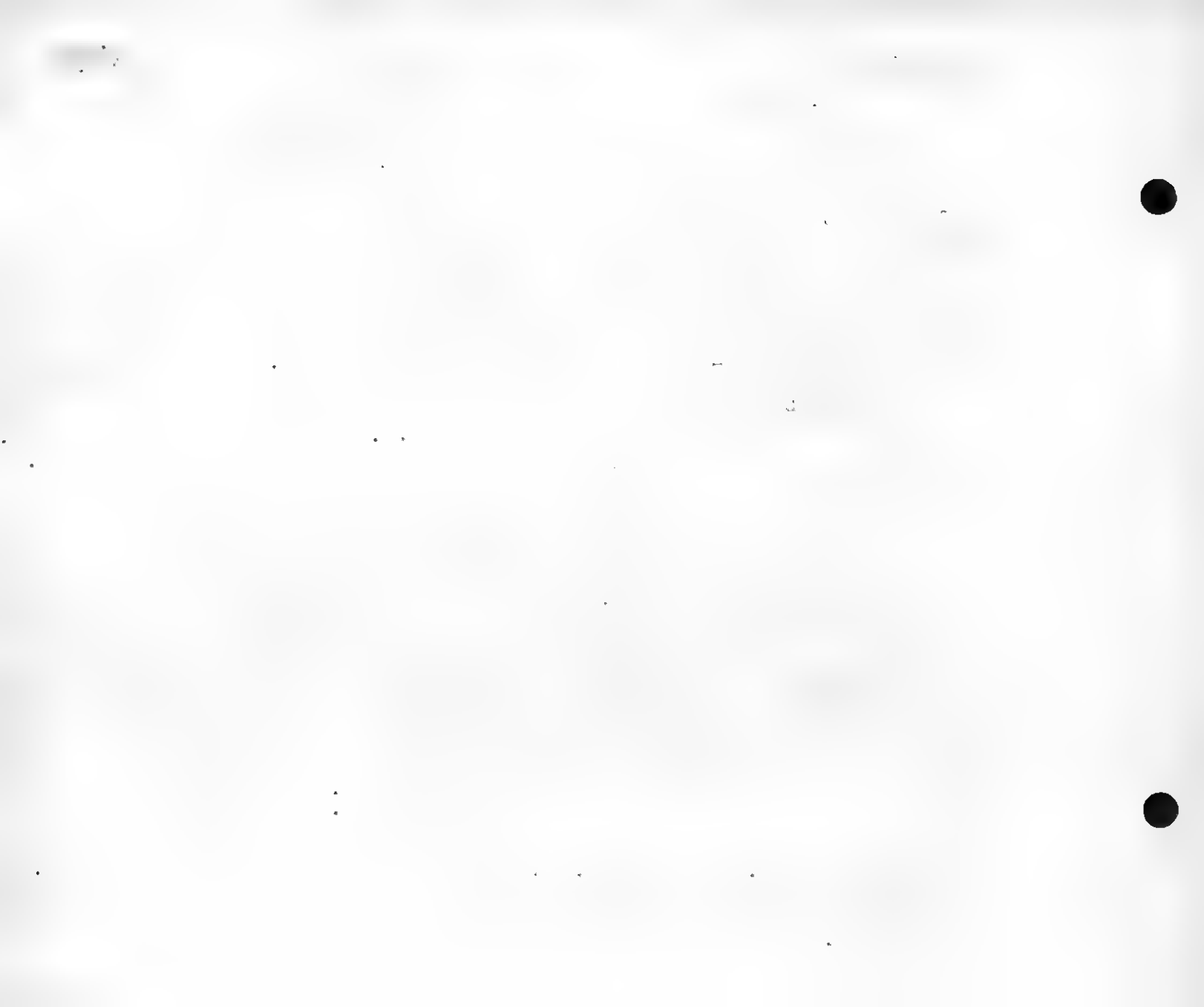
## CERTIFICATE OF DEATH

09216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY # 1b <b>6/29/1966</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Allegany County Infirmary</b>		d. STREET ADDRESS <b>725 Gephart Drive</b>	
3 NAME OF DECEASED (Type or print) First <b>Angus</b> Middle <b>Bruce</b> Last <b>Kirkland</b>		4 DATE OF DEATH Month <b>July</b> Day <b>17</b> , Year <b>1966</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>2/4/1885</b>
9 AGE (In years last birthday) yrs <b>81</b>		IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b> Hours <b>17</b> Min. <b>17</b>	
10a. OCCUPATION (Give kind of work done during most of work no. life, even if retired) <b>Retired: Salesman-Schwarzenbach's</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Jamaica, B. C.</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>U. S. A.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13 FATHER'S NAME <b>Ambrose Kirkland</b>		14 MOTHER'S MAIDEN NAME <b>Clara Livingston</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>170-01-8360</b>	
17 INFORMANT <b>P.O. Box 599, Address: Cumberland, Md. Allegany County Infirmary records.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>① Atherosclerosis Cardiovascular</b> DUE TO (b) <b>disease of Hypertension - Primary cardiac</b> DUE TO (c) <b>② Uncontrolled diabetes mellitus ③ Bilateral Cataracts</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6/29/66</b> , 19__, to <b>7/17/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>7/16/66</b> , 19__, and that death occurred at <b>P. M.</b> from causes and on the date stated above			
22a. SIGNATURE <b>Lee B. Mathews, M. D.</b>		22b. DATE SIGNED <b>7/19/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lee B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/20/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>	
ADDRESS <b>Cumberland, Maryland 21502</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



09225

## CERTIFICATE OF DEATH

09217

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e STREET ADDRESS <b>PINEY MOUNTAIN ROAD</b>	
3 NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>E.</b> Last <b>LANCASTER</b>		4 DATE OF DEATH Month <b>JULY</b> Day <b>26TH</b> Year <b>1966</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>DEC. 26th, 1907</b>
9. AGE (In years last birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR Months Days Hours M.n.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BOWLING ALLEY</b>	
11. BIRTHPLACE (County & State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES LANCASTER</b>		14. MOTHER'S MAIDEN NAME <b>MARY PAPE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-10-5143</b>	
17. INFORMANT <b>MRS. VIVA LANCASTER,</b>		Address <b>ECKHART, PINEY MT. ROAD, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma lungs</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastasis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 19 1966</b> to <b>July 26 1966</b> that (I) (we) last saw the deceased alive on <b>July 24 1966</b> and that death occurred at <b>7 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John B. Davis, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/27/66</b>
22c. PHYSICIAN'S NAME (Type) <b>JOHN B. DAVIS,</b>		22d. ADDRESS <b>2 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ECKHART CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>ECKHART, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.</b>		ADDRESS <b>FROSTBURG, MD.</b>	
25a. REC'D BY REGISTRAR DATE <b>AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



09226

## CERTIFICATE OF DEATH

09218

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG,</b>	
c. LENGTH OF STAY IN 1b <b>5 DAYS</b>		d. STREET ADDRESS <b>19 BOWERY ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MINERS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARTHA JANE LEWIS</b>		4. DATE OF DEATH Month Day Year <b>JULY 26th, 19 66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 15th, 1883</b>
9. AGE (In years last birthday) <b>83 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR IND. STRY <b>OWN HOUSEWORK</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>DAVID L. JONES</b>		14. MOTHER'S MAIDEN NAME <b>ALICE LEWIS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>OWEN LEWIS, 19 BOWERY ST., FROSTBURG, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial ischemia.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Congestive failure.</b> DUE TO (c) <b>A.S.C.V.D.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>July 21, 19 66</b> to <b>July 26 19 66</b> that (I) (we) last saw the deceased alive on <b>July 26 1966</b> , and that death occurred at <b>5:30 PM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Alvin J. Walters</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>ALVIN J. WALTERS,</b>		22d. ADDRESS <b>48 BROADWAY, FROSTBURG, MD.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>7-29-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>F.B.G. MEMORIAL PARK,</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 1 1966</b>	
ADDRESS <b>FROSTBURG, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





09227

## CERTIFICATE OF DEATH

09219

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN b <b>9 DAYS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>J.</b> Last <b>LOGSDON</b>				4. DATE OF DEATH Month <b>JULY</b> Day <b>17</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 6, 1884</b>		9. AGE (In years and birthday) yrs <b>82</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee B&amp;O RR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>GEORGE LOGSDON</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET ALKIRE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis &amp; Decompensation</b> 5410 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden death</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b> <b>3 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS A T.O.P.S. PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>July 11, 1966</b> to <b>July 17, 1966</b> ; that (I) (we) last saw the deceased alive on <b>July 17, 1966</b> and that death occurred at <b>12:20 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Richard J. Williams</b> <b>p/ Clayton Burnett</b> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/20/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>		22d. ADDRESS <b>K 122 S. CENTRE ST., CUMBERLAND, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 20, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Md.</b>	
24. FUNERAL DIRECTOR <b>H. Lee Silcox 404 Decatur Street</b>				25a. REC'D BY REGISTRAR <b>JUL 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James J. J...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and many event, within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. First pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09228

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09220

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Maryland</b>		c. LENGTH OF STAY IN b <b>24 hours</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, (Bowling Green)</b>		d. STREET ADDRESS <b>455 Bowling Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Mary R. Manual</b>		4. DATE OF DEATH <b>July 15 1966</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-12-1903</b>		9. AGE (In years, last birthday) <b>63 yrs</b>		10. FUND 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>									
11. BIRTH-PLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ernest T. Stolle</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Stafford</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Memorial Hospital Cumberland, Md.</b>		18. ADDRESS									
B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>1201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Coronary Occlusion</b> <b>Coronary Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>----</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <b>July 15, 1966</b>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>		ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Charles Town, Jeff. W. Va.</b>	
24. FUNERAL DIRECTOR <b>Melvin T. Snyder</b>		ADDRESS <b>W. Va.</b>		25a. REC'D BY REGISTRAR <b>JUL 18 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		26. RECORD BY REGISTRAR <b>JUL 18 1966</b>		26b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		27. RECORD BY REGISTRAR <b>JUL 18 1966</b>		27b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		28. RECORD BY REGISTRAR <b>JUL 18 1966</b>		28b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20 M 1/66

09223

CERTIFICATE OF DEATH

09221

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>5 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL CO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT ASHBY,</b> d. STREET ADDRESS <b>MEMORIAL HOSPITAL</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Myrtle First Middle M. Marker</b> 5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>1966</b> 8. DATE OF BIRTH <b>JULY 8, 1908</b> 9. AGE (In years lost birthday) yrs <b>58</b> 11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HARRY H. BROOME</b>		14. MOTHER'S MAIDEN NAME <b>SALLY MALONE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal failure</b> DUE TO (b) <b>pyelonephritis</b> DUE TO (c) <b>Intercapillary glomerular sclerosis</b> Diabetes and arteriosclerosis CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>5 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive and arteriosclerotic cardiovascular disease</b>		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACC. DEM. WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1460</b>		20f. (City or town) (County) (State) <b>7/19, 1966</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1960</b> <b>6:10 p.m.</b> <b>7/19, 1966</b> , that (I) (we) lost saw the deceased alive on <b>7/19, 1966</b> , and that death occurred at <b>M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. S. G. Weisman</b> 22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>		22b. DATE SIGNED <b>7/21/66</b> 22d. ADDRESS <b>800 GREENE ST. CUMB MD.</b>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 22, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fort Ashby, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>		25a. RECD BY REGISTRAR <b>JUL 27 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



09230

CERTIFICATE OF DEATH

09222

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN lb <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING, MD.</b> d. STREET ADDRESS <b>19 ROCKVILLE ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN</b> First Middle Last <b>MARSHALL</b>		4. DATE OF DEATH Month Day Year <b>JULY 5 19 66</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 4, 1908</b> 9. AGE (In years last birthday) <b>58</b> yrs.
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Allegany County Road Worker</b>		11. BIRTHPLACE (County & State, or foreign country) <b>LONA CONING, MD.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MARSHALL</b>		14. MOTHER'S MAIDEN NAME <b>RACHAEL SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MEMORIAL HOSPITAL</b> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Pulmonary Thrombosis</b> DUE TO (b) <b>Central nervous system Cerebral Vascular Disease</b> DUE TO (c) <b>Post</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>July 3-6 1966</b> P.M. <b>July 5, 1966</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>July 5</b> 1966, and that death occurred at <b>7/6/66</b> M, from causes on the date stated above.			
22a. SIGNATURE <b>DR. G. OVERTON HIMMELWRIGHT</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>7/6/66</b>
22c. PHYSICIAN'S NAME (Type) <b>DR. G. OVERTON HIMMELWRIGHT</b>		22d. ADDRESS <b>133 VIRGINIA AVE. CUMB. MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Frostburg, A. Md</b>
24. FUNERAL DIRECTOR <b>George Eichhorn</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 8 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





09231

## CERTIFICATE OF DEATH

09223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is detached, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>Mineral</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEYSER</b>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>72 AST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLAUDE</b> First <b>Arlington?</b> Middle <b>MARTIN</b> Last		4. DATE OF DEATH <b>JULY</b> Month <b>28</b> Day <b>19</b> Year <b>66</b>		5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Retired Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Garage</b>		9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>1</b> Min		IF UNDER 24 HRS. Hours <b>1</b> Min	
13. FATHER'S NAME <b>THOMAS(D) Martin</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN ( PARRILL) (D)</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Antioch, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>213-01-5513</b>		17. INFORMANT <b>PT'S CHART &amp; Pearl S. Martin--Wife</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7-8</b> , 19 <b>66</b> , to <b>7-28</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-28</b> , 19 <b>66</b> , and that death occurred at <b>7:25</b> P.M., from causes and on the date stated above.									
22a. SIGNATURE <b>W. Spiggle</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7-29-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>DR. GLICK &amp; SPIGGLE, MD.</b>		22d. ADDRESS <b>126 N. SMALLWOOD ST. CUMBERLAND, MARYLAND</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-31-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Moscow, Md. Allegany</b>			
24. FUNERAL DIRECTOR <b>Thomas Smith Jr.</b>		ADDRESS <b>Keyser, W. Va.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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FOR STATE  
HEALTH DEPT.

092322

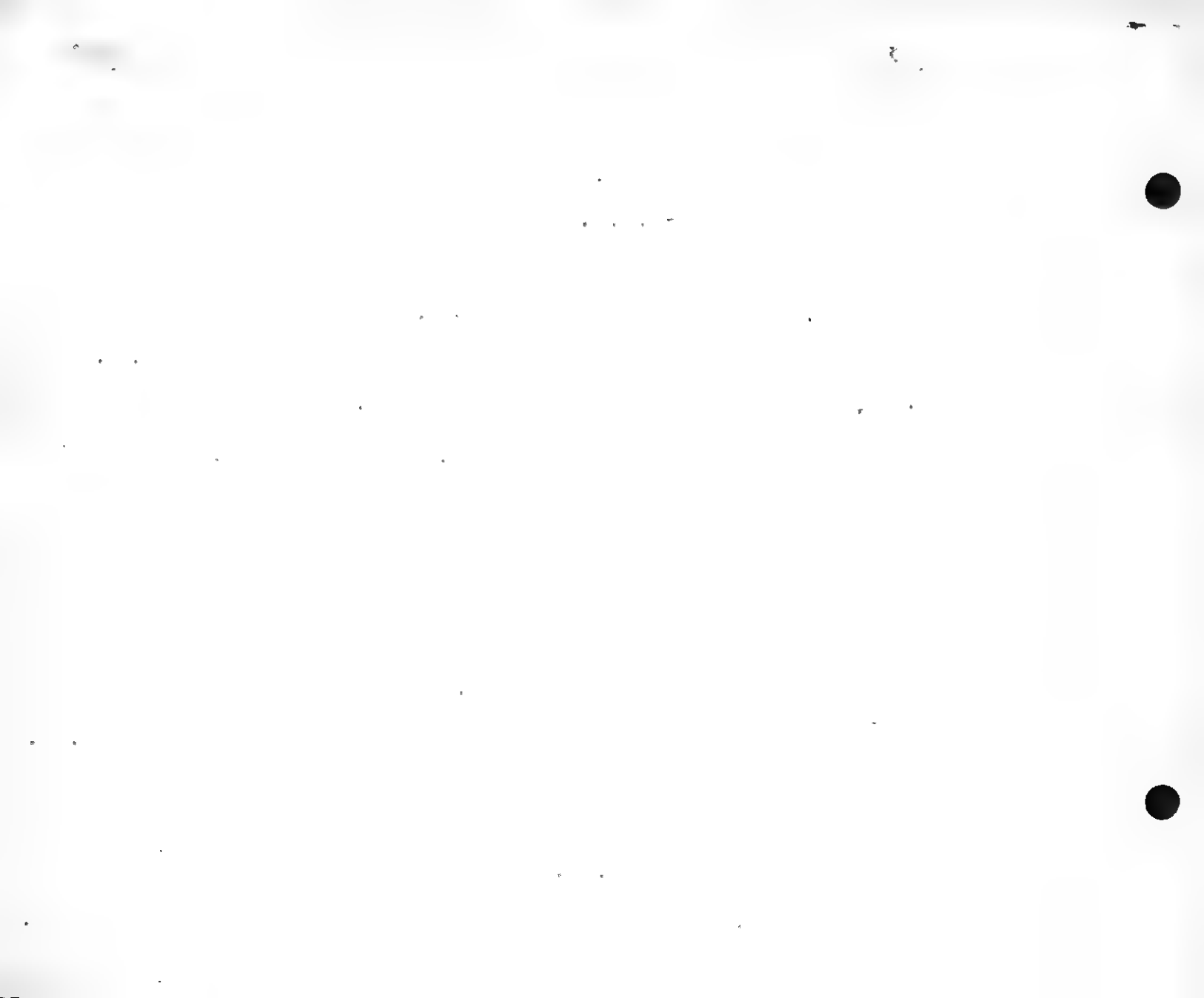
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09224

1 PLACE OF DEATH a COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>West Virginia</b> b COUNTY <b>Hampshire</b> ✓	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c LENGTH OF STAY N 1b <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <b>Memorial Hospital--D.O.A.</b>		e STREET ADDRESS <b>Levels</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Harvey Earl Martin</b>		4 DATE OF DEATH Month Day Year <b>July 23 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 3, 1946</b>
9 AGE (In years last birthday) yrs <b>19</b>		10 UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Cabinet Maker</b>	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>John T. Martin</b>		14 MOTHER'S MAIDEN NAME <b>Twila S. Saville</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>235-72-1324</b>	
17 INFORMANT <b>John T. Martin,</b>		Address <b>Levels, West Virginia</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Intracranial Hemorrhage, Massive</b> DUE TO (b) <b>Skull Fracture</b> DUE TO (c) <b>(Motorcycle Accident)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>90 Minutes</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Overtured on own cycle</b>	
20c TIME OF INJURY Month, Day, Year Hour <b>8:30</b> pm <b>July 23 1966</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>Hwy near Points, Points, Hamp. W.Va.</b>		20f (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 23, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Cumberland, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>July 26, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Wesley Chaple</b>	23d LOCATION (City or Town) (County) (State) <b>Points Hampshire W.Va.</b>
24. FUNERAL DIRECTOR <b>Booth Schaffer Romney</b>		25a REC'D BY REGISTRAR DATE <b>JUL 26 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09233

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09225

1 PLACE OF DEATH a COUNTY <u>Allegheny</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegheny</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN TB <u>88 years</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williams Road</u>		e STREET ADDRESS <u>Williams Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>J.</u> Last <u>Martin</u>		4 DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 15, 1880</u>
9 AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11 BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>Joseph Helmstetter</u>	
14 MOTHER'S MAIDEN NAME <u>Barbara Rahrig</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16 SOCIAL SECURITY NO. <u>  </u>		17 INFORMANT <u>Mrs. Richard M. Stermaier, Cumberland, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201</u> DUE TO CORONARY OCCLUSION CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>--</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>  </u>	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>
20f (City or town) <u>  </u>		(County) <u>  </u> (State) <u>  </u>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Rt. <u>Cumberland</u>	
Address (Street, city, town, or county) <u>  </u>		22 DATE SIGNED <u>July 18-66</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>July 21, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Cumberland, Md. - Allegheny</u>
24 FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>		25a REC'D BY REGISTRAR DATE <u>JUL 21 1966</u>	
ADDRESS <u>  </u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



09234

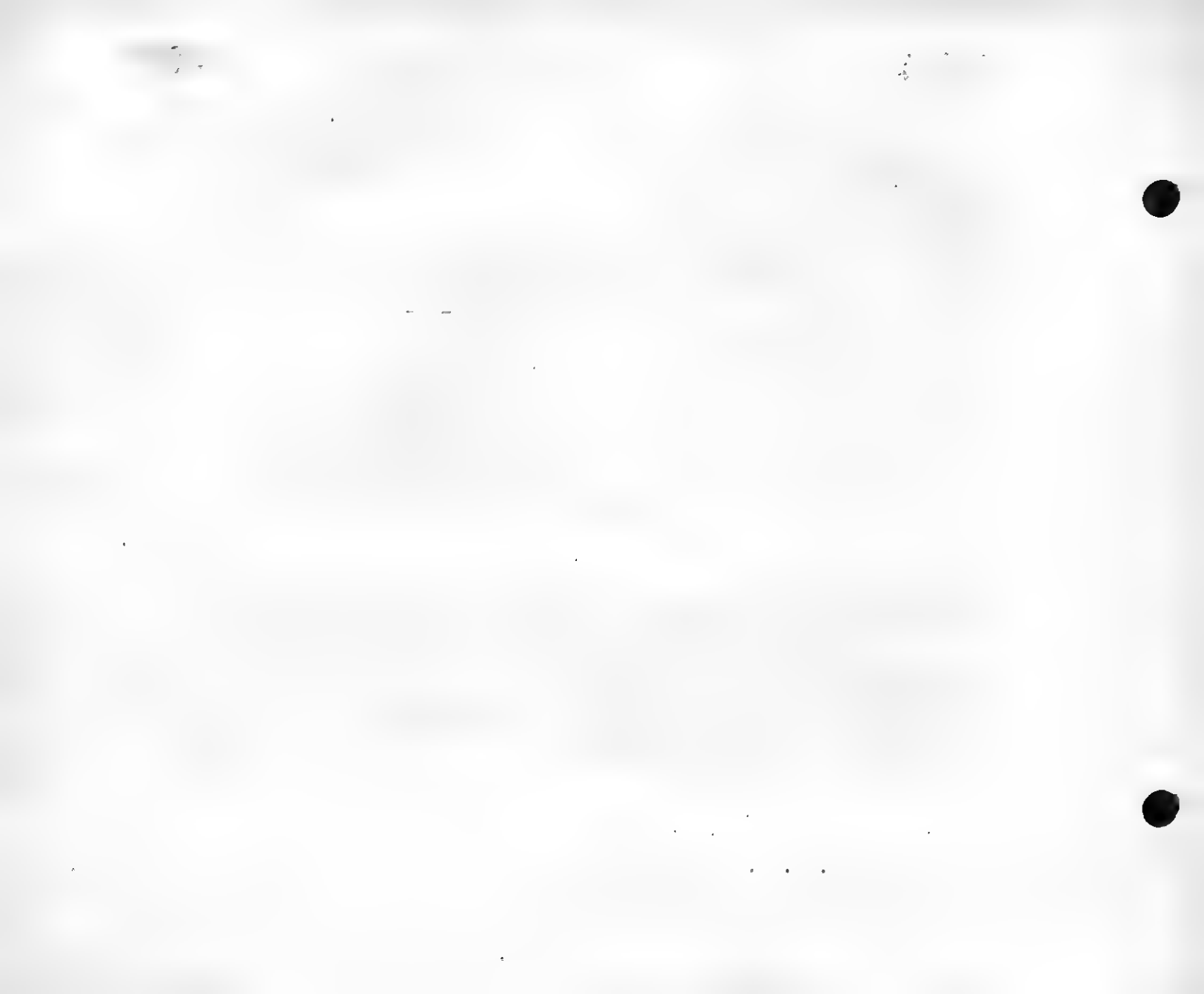
## CERTIFICATE OF DEATH

09226

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if inst. lcl on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LITTLE ORLEANS</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>EDWARD</b> Last <b>MARTIN</b>		4 DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>19 66</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>11-20-07</b>
9 AGE (In years) <b>58</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND, LITTLE ORLEANS</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD R. MARTIN</b>		14. MOTHER'S MAIDEN NAME <b>WINNIE MARTIN CHRISTINA SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>PATIENT'S CHART</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary heart failure, Rt + left</b> DUE TO <b>Arteriosclerosis Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Arteriosclerosis of legs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 year</b>	
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>1966</b> , to <b>7/22, 1966</b> , that (I) (we) last saw the deceased alive on <b>7/22, 1966</b> , and that death occurred at <b>9:50</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. S. G. Weisman</b>		22b. DATE SIGNED <b>7/22/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>		22d. ADDRESS <b>59 GREENE ST., CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 25, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Martin Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Little Orleans, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarnelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>J. Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>JUL 27 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

09227

09235

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>Rt. #1 Box 497</b>	
3. NAME OF DECEASED (Type or print) <b>Thomas J. Martin</b>		4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-34</b>
9. AGE (in years and birthday) <b>32</b> yrs		10. IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Powder man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ABL</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Allegany, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Bernard Martin</b>		14. MOTHER'S MAIDEN NAME <b>Hilda Delany</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO <b>220-32-4887</b>	
17. INFORMANT <b>Mrs. Thos. Martin, Frostburg, Md. Rt. 1</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, massive</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } lost } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-22</b> , 19 <b>66</b> , to <b>7-24</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7-24</b> , 19 <b>66</b> , and that death occurred at <b>1 p</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Ralph W. Ballin</b>		22b. DATE SIGNED <b>7-25-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		22d. ADDRESS <b>62 Greene S. Cumberland, Md. 21502</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>JULY 27, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>	23d. LOCATION (City or Town) (County) (State) <b>FROSTBURG, MD.</b>
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JUL 29 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 2 3  
4 5 6



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

09236

09228

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md. Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>208 Columbia St.</u>		d. STREET ADDRESS <u>208 Columbia St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>A.</u> Last <u>McKenzie</u>		4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1884</u>
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <u>Retired Brakeman W.M. R.R.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Md. U.S.A</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Enoch McKenzie</u>		14. MOTHER'S MAIDEN NAME <u>Cecelia Whitacre</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr. William McKenzie</u>	
17. INFORMANT Address <u>Cumb. Md.</u>		18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning artery disease</u> DUE TO (b) <u>open lacerated antenatal lesion</u> DUE TO (c) <u>young</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>July 11</u> 19 <u>66</u> to <u>July 12</u> 19 <u>66</u> (that I) (we) last saw the deceased alive on <u>July 11</u> 19 <u>66</u> and that death occurred at <u>7:11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7/13/66</u>	
22c. PHYSICIAN'S NAME (Type) _____		22d. ADDRESS <u>43 Greene Street Cumb. Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>7/15/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>		23d. LOCATION (City, town or county) <u>Cumberland Md</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Cumb. Md.</u>		25b. REGISTRAR'S SIGNATURE _____	
DATE <u>JUL 18 1966</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, the certificate should be removed from the file and any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



09229

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE-  
HEALTH DEPT.

09237

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Allegany</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN 1b <u>40 years</u>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>62 Maple St.</u>		a STREET ADDRESS <u>62 Maple St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>A.</u> Last <u>Mencer</u>		4 DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 2, 1892</u>
9 AGE (In years last birthday) yrs <u>74</u>		10 UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of workng life even if retired) <u>housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Cwn Home</u>	11 BIRTHPLACE (State or foreign country) <u>Picardy, Maryland</u>
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13 FATHER'S NAME <u>John Miller</u>	
14 MOTHER'S MAIDEN NAME <u>Anna ?</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>	
16 SOCIAL SECURITY NO. <u>  </u>		17 INFORMANT <u>Mrs. Kenneth Perry, Cumberland, Md.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>114X</u> DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) DUE TO		INTERVAL BETWEEN MINUTES <u>  </u>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> July 10, 1966	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/> July 10, 1966	
Address (Street, city, town, or county) <u>Cumberland, Md.</u>		22. DATE SIGNED	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>July 13, 1966</u>	23c NAME OF CEMETERY OR CREMATORY <u>Picardy Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Picardy, Maryland</u>
24 FUNERAL DIRECTOR <u>James F. Scarnelli, Cumberland, Md.</u>		25a REC'D BY REGISTRAR DATE <u>JUL 18 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S NAME <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

C9233

09230

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>118 N. Smallwood St.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md. 01-1</u> d. STREET ADDRESS <u>118 N. Smallwood St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>A.</u> Last <u>Mullaney</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/3/02</u> 9. AGE (In years last birthday) <u>63</u> yrs. 10. FUNDERS 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Stratensburg Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Greene</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Thomas H. Mullaney, Cumb Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 mon</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-29</u> , 19 <u>65</u> , to <u>7-27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-21</u> , 19 <u>66</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>7-28-66</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22d. ADDRESS				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter &amp; Paul Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>	
24. FUNERAL DIRECTOR <u>Louis Stein Inc. Cumb. Md</u> ADDRESS				25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
DATE <u>AUG 2 1966</u>							





VR A15ME (5)  
6M 1/66

09239

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before institution) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>			d. STREET ADDRESS <b>433 Seymour Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Annan</b>		Middle <b>G.</b>		Last <b>Myers</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 25, 1904</b>		9. AGE (In years last birthday) <b>61</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City Products Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>	
13. FATHER'S NAME <b>Frank Myers</b>			14. MOTHER'S MAIDEN NAME <b>Annie Griffith</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>214-05-5108</b>		17. INFORMANT Address <b>Mrs. Dorothea Myers, Cumberland, Md.-Wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>5910</b> IMMEDIATE CAUSE (a) <b>Gastric Hemorrhage, Massive</b> DUE TO (b) <b>Ruptured Esophageal Varices</b> DUE TO (c) <b>Portal Cirrhosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarlic</b>		EXAMINER'S NAME (Type) <b>BENEDICT SKITARLIC, M.D.</b>		22. DATE SIGNED <b>July 14, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 16, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Restlawn Memorial Park</b>	
				23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>	
24. FUNERAL DIRECTOR <b>James F. Scarnelli, Cumberland, Md.</b>			25a. REC'D BY REGISTRAR <b>JUL 19 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 is retained by the hospital or attending physician. Page 2 is retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09240					09232				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		ALLEGANY			a. STATE		b. COUNTY		
		MARYLAND			MARYLAND		ALLEGANY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		FROSTBURG			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		FROSTBURG		
		40 YEARS							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
61 LINDEN STREET					61 LINDEN STREET				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
CORA		E.		MYERS		JULY		26 1966	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		JUNE 22, 1890		76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
SEAMSTRESS		PAJAMA FACTORY		BORDEN MINES		U.S.A.			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JOHN J. JOHNS					ANNIE BRODE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO., 17. INFORMANT				
NO					212-01-9741 MRS. CATHERINE SKIDMORE, 118 ORMOND ST.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
461 DUE TO Acute myocardial infarction									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension									
(c) Anterior Sclerotic Heart disease									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
Sanility									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. 19									
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 10-4 1966 to 7-25 1966, that (I) (we) last saw the deceased alive on 7-25 1966, and that death occurred at 8A M, from the causes and on the date stated above.									
22a. SIGNATURE H.C. Diehl M.D.									
22b. DATE SIGNED 7/29/66									
22c. PHYSICIAN'S NAME (Type) H. C. DIEHL, M.D.									
22d. ADDRESS 39 WEST MAIN ST., FROSTBURG, MD.									
23a. BURIAL, CREMATION, 23b. DATE THEREOF									
REMOVAL (Specify) BURIAL JULY 29, 1966 FROSTBURG MEM. PARK FROSTBURG, MARYLAND									
24. FUNERAL DIRECTOR'S SIGNATURE HAFER FUNERAL HOME									
MARILOU SOWERS, 60 W. MAIN ST., FROSTBURG									
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE									
AUG 1 1966 Charles J. J...									



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (4)  
GM 1/766

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09233

1 PLACE OF DEATH a COUNTY <b>Allegany</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Route #3</b>		c LENGTH OF STAY IN b <b>22 Years</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland Route #3</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Allen</b> Last <b>Norris</b>			4 DATE OF DEATH Month <b>July</b> Day <b>21</b> Year <b>19 66</b>		
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept 17, 1881</b>	9 AGE (In years last birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Merchant</b>		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13 FATHER'S NAME <b>Andrew J. Norris</b>			4 MOTHER'S MAIDEN NAME <b>Mary F. Stottlemeyer</b>		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>216-38-2012</b>	17 INFORMANT <b>Mrs. Mary Norris</b> Address <b>Rt #3- Box 216 Cumberland, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>4201 IMMEDIATE CAUSE (a) Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c) <b>-----</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>July 21, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>7/23/66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Piney Grove Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Piney Grove Wash Co Maryland</b>	
24 FUNERAL DIRECTOR <b>H. Lee Silcox</b>		ADDRESS <b>Cumberland Maryland 21502</b>		25a REC'D BY REGISTRAR <b>JUL 25 1966</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

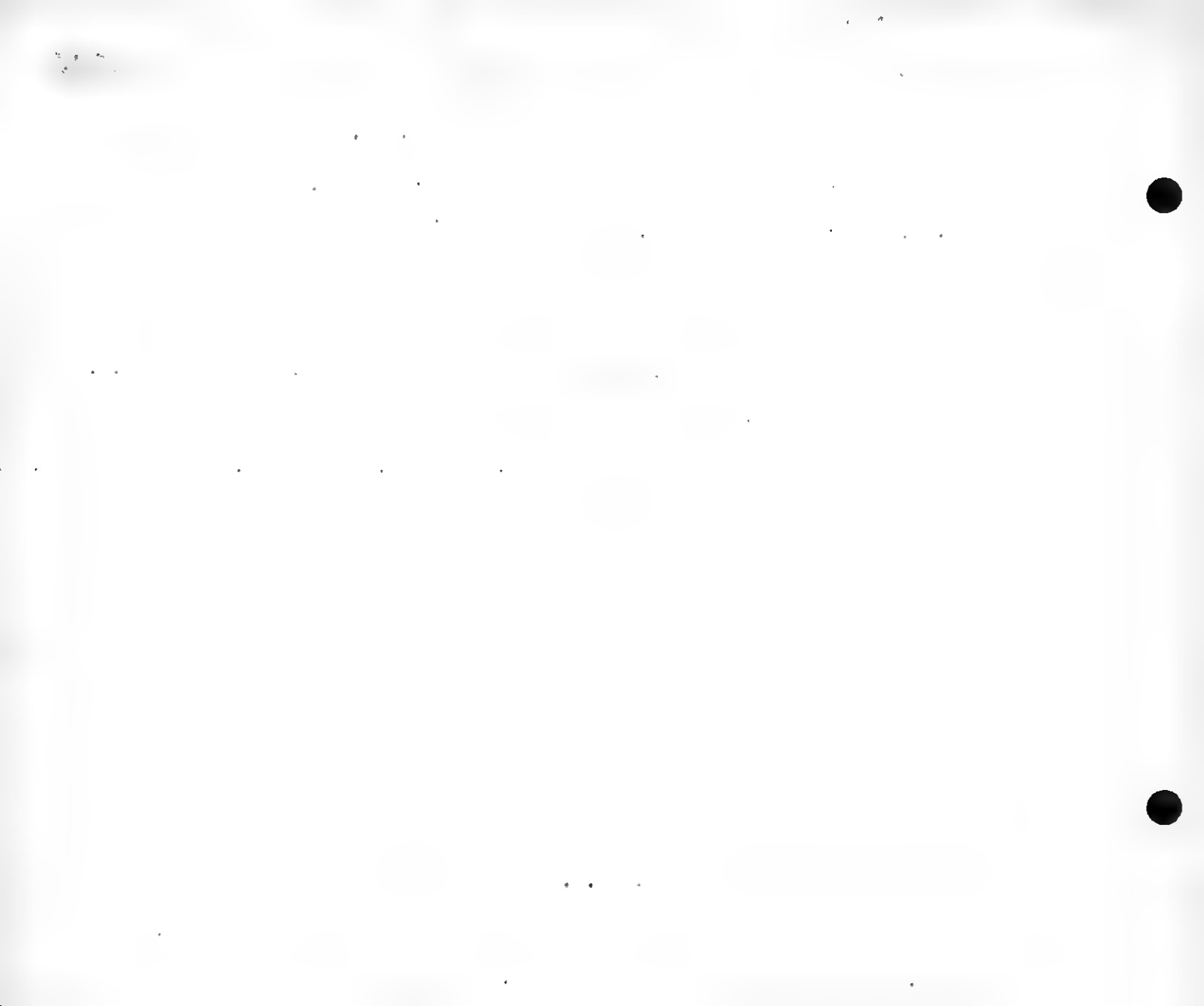
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09234

1 PLACE OF DEATH a COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <u>W. Va.</u> b COUNTY <u>Mineral</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c LENGTH OF STAY IN 1d <u>Rt. # 1 Ridgeley</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D. O. A. Sacred Heart Hosp.</u>		e STREET ADDRESS <u>Old Furnace Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Michael</u> Last <u>O'Brien</u>		4 DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1966</u>	
5 SEX <u>male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4/11/16</u>
9 AGE (In years last birthday) <u>50</u> yrs		F UNDER 1 YEAR Months <u>  </u> Days <u>  </u> HOURS <u>  </u> MIN <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11 BIRTHPLACE (State or foreign country) <u>Deer Park, Md.</u>		12 CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert E. O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Ella May Valentine</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>236-50-0578</u>	
17 INFORMANT <u>Mr. Robert E. O'Brien</u>		Address <u>Rt. # 1 Ridgeley, W. Va.</u>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>451X</u> DUE TO <u>MEDIASTINAL HEMORRHAGE, HEMOTHORAX, LEFT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>RUPTURE OF DISSECTING ANEURYSM OF AORTA</u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/8/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Ft. Ashby Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Ft. Ashby, W. Va.</u>	
24 FUNERAL DIRECTOR <u>H. Wayne George</u>		25a REC'D BY REGISTRAR <u>Cumberland, Md.</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 11 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and retain a copy of the permit.





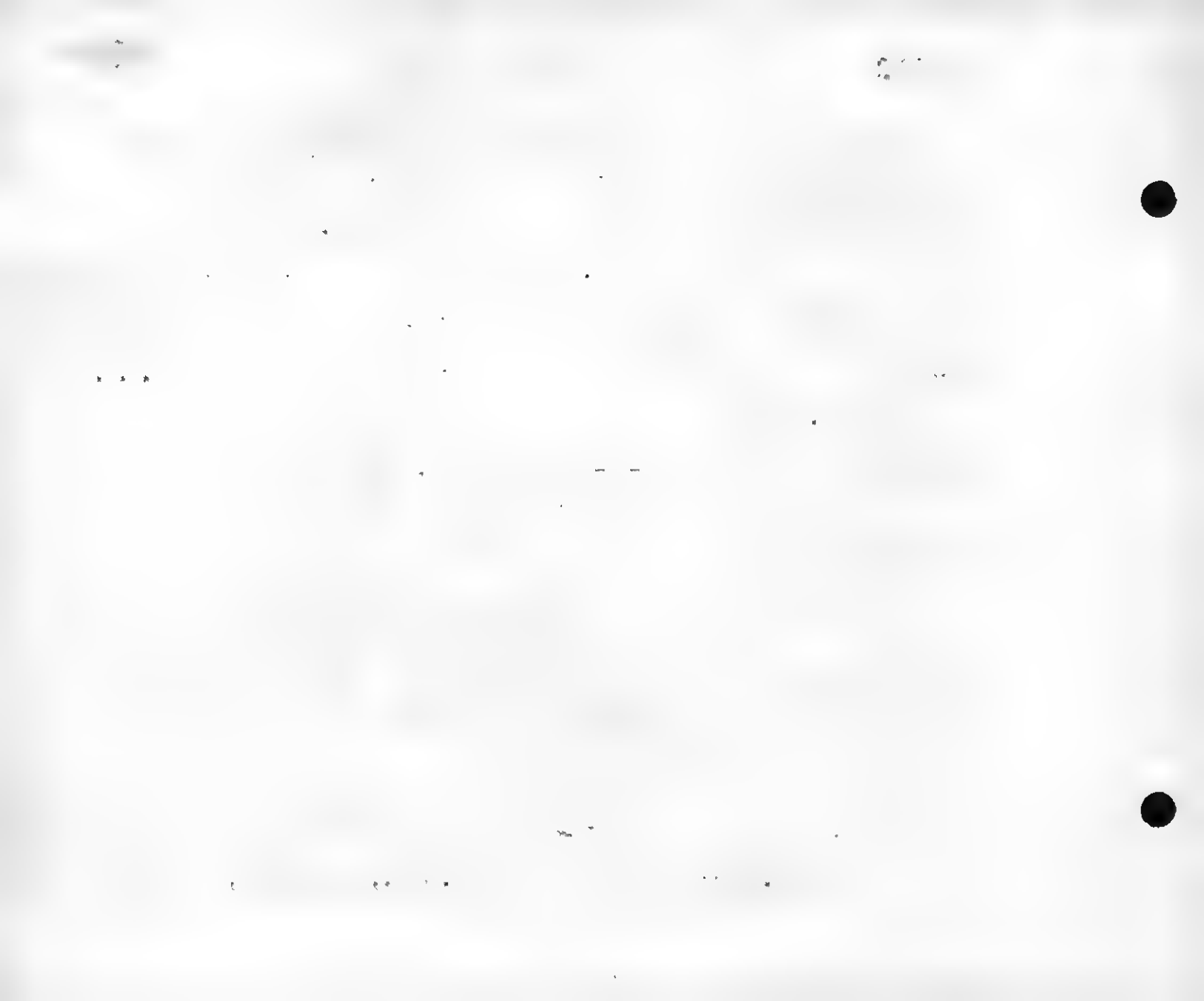
C9243

CERTIFICATE OF DEATH

09235

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1a <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		e. STREET ADDRESS <b>232 GLENN ST.</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>PAUL R. PERDEW</b>		4. DATE OF DEATH Month Day Year <b>July 25, 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 1, 1904</b>
9 AGE (In years last birthday) <b>62 yrs</b>		10 UNDER 1 YEAR Months Days	11 UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13 FATHER'S NAME <b>John M. Perdeu</b>	
14 MOTHER'S MAIDEN NAME <b>Nellie (Cessna) Perdeu</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO. <b>220-16-16429</b>		17 INFORMANT <b>Mrs. Elma C. Perdeu, 232 Glenn St., Cumberland Pts. Chart</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <b>Globuloma Brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Left Hemiplegia</b> DUE TO <b>Cerebro sclerosis</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>3 wks</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 5, 19 66 to July 25, 19 66</b> that (I) (we) last saw the deceased alive on <b>July 24, 19 66</b> and that death occurred at <b>7:45 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Clay E. Durrett</b> M.D.		22b. DATE SIGNED <b>7/25/66</b>	22c. PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>
22d. ADDRESS <b>Va. Ave., Cumberland, Maryland</b>		22e. REC'D BY REGISTRAR <b>John J. Hafer</b>	
22f. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>		22g. DATE <b>JUL 29 1966</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 27, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Cumberland, Maryland</b>	
24 FUNERAL DIRECTOR <b>John J. Hafer</b> <b>John J. Hafer, 230 Balto Ave., Cumberland, Md</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only decay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09244

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09236

1 PLACE OF DEATH a COUNTY <b>Allegany</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Allegany</b>		
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland Route #2</b>		c LENGTH OF STAY IN 1b <b>40 Years</b>		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cumberland Route #2</b> / /	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d STREET ADDRESS		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last <b>Carrie Elizabeth Raines</b>			4 DATE OF DEATH Month Day Year <b>July 19 1966</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>October 8, 1883</b>	9 AGE (In years last birthday) <b>82 yrs</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11 BIRTH-PLACE (State or foreign country) <b>Flintstone, Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13 FATHER'S NAME <b>John H. Smith</b>		
14 MOTHER'S MAIDEN NAME <b>Florence DeHaven</b>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		
16 SOCIAL SECURITY NO			17 INFORMANT Address <b>Mrs. Vanna Wilson Route #2 Cumberland, Md</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiovascular disease --</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f (City or town)	(County)	(State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
22. DATE SIGNED <b>July 19, 1966</b>		23a REC'D BY REGISTRAR <b>J. Charles Judge</b>			
23b REG STRIP'S SIGNATURE		23c NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cemetery</b>			
23d LOCATION (City or Town) (County) (State) <b>Cumberland Allegany Maryland</b>		23e ADDRESS <b>H. Lee Silcox Cumberland, Maryland 21502</b>			
23f DATE <b>JUL 25 1966</b>		23g			



FOR STATE HEALTH DEPT.

09245

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09237

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>20 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>516 Hilltop Drive</b>				d. STREET ADDRESS <b>516 Hilltop Drive</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Agnes</b> Last <b>Raybould</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>19 46</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1899</b>		9. AGE (In years last birthday) <b>67</b> yrs	10. IF UNDER 1 YEAR Months <b>1</b> Days <b>6</b> Hours <b>19</b> Mins <b>46</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles A. Raybould</b>				14. MOTHER'S MAIDEN NAME <b>Annie Raybould</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes No or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>213-12-9722</b>		17. INFORMANT <b>Elza R. Here</b>		Address <b>516 Hilltop Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>H &amp; O I</b> DUE TO <b>CORONARY SCLEROSIS</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <b>---</b> (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>SODDEN</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>July 6, 1966</b>	
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Charles Judge</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>7/9/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park Inc.</b>	
23d. LOCATION (City or Town) (County) (State) <b>Allegany Md.</b>				23e. REC'D BY REGISTRAR <b>JUL 11 1966</b>		23f. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Louis Sturish</b> ADDRESS <b>Cumt. Md.</b>				25. REC'D BY REGISTRAR <b>JUL 11 1966</b>			



FOR STATE  
HEALTH DEPT.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09238

1 PLACE OF DEATH a COUNTY <b>Allegheny</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Allegheny</b>	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c LENGTH OF STAY IN Ia <b>71 years</b>	
d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		d STREET ADDRESS <b>714 Glenmore St.</b>	
3 NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>F.</b> Last <b>Rice</b>		4 DATE OF DEATH Month <b>July</b> Day <b>3</b> Year <b>66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>March 15, 1895</b>
9 AGE (In years and birthday) <b>71 yrs</b>		10 FUNDING YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Caller</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11 BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Thomas H. Rice</b>		14 MOTHER'S MAIDEN NAME <b>Laura E. Smeltzer</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO	
17 INFORMANT <b>Mrs. Minnie Rice, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>CORONARY SCLEROSIS</b> (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN</b> <b>---</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D. EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>		22. DATE SIGNED <b>July 3, 1966</b> Address (Street, city, town, or county) <b>Cumberland, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>July 6, 1966</b>	23c NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegheny</b>
24 FUNERAL DIRECTOR <b>James F. Scarnelli, Cumberland, Md.</b>		25a REC'D BY REGISTRAR DATE <b>JUL 11 1966</b>	
		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a file certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

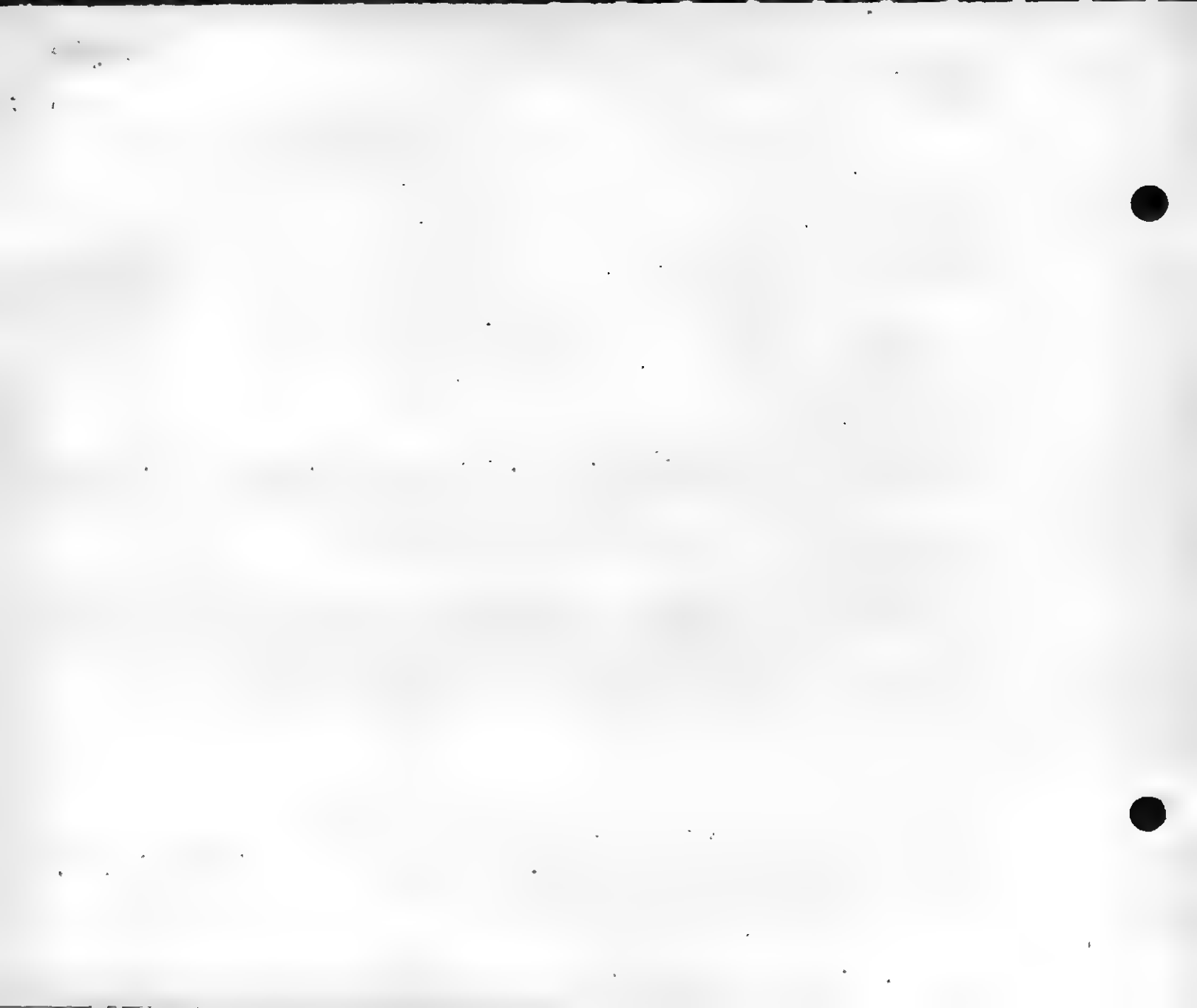
09247

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09239

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>R D 4, Oldtown</u>		c. LENGTH OF STAY IN ID <u>Sudden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summer Camp, Town Creek Road</u>		e. STREET ADDRESS <u>Route 4</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Wilda</u> Last <u>Ritchio</u>		4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 31, 1916</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lionel Piper</u>		14. MOTHER'S MAIDEN NAME <u>Emma Moreland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-18-1433</u>	
17. INFORMANT <u>Mrs. Norman Campbell</u>		Address <u>507 Beall St., Cumberland Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>4201</u> DUE TO <u>CORONARY SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause test. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		22. DATE SIGNED <u>July 23, 1966</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		Address (Street, city, town, or county) <u>Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 26, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Davis Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Near Cumberland, Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Hafet</u>		25a. REC'D BY REGISTRAR <u>John J. Hafet</u>	
25b. REGISTRAR'S SIGNATURE <u>John J. Hafet</u>		25c. REGISTRAR'S SIGNATURE <u>John J. Hafet</u>	

DATE JUL 26 1966



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09248

CERTIFICATE OF DEATH

09240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>RIDGELEY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>108 KNOBLEY ST.</b>	
3 NAME OF DECEASED (Type or print) First <b>GERTIE</b> Middle <b>MARY</b> Last <b>ROYCE</b>		4. DATE OF DEATH Month <b>JULY</b> Day <b>22</b> Year <b>1966</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4/21/02</b>
9 AGE (In years last birthday) <b>64</b> yrs		10 IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>15</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11 BIRTHPLACE (County & State or foreign country) <b>Spring Gap Mt., W. Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Anthony P. Pohrer</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Shanholtz</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>pt8s. chart</b>	
17. INFORMANT <b>pt8s. chart</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>Coronary Artery Disease w/</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Insufficiency</b> (b) <b>Insufficiency</b> (c) <b>Insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 mins</b> <b>2 yrs</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan.</b> , 19 <b>65</b> , to <b>July 22, 1966</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>July 22, 1966</b> , and that death occurred at <b>7:50 A.M.</b> , from causes and on the date stated above.			
22a SIGNATURE <b>Dr. Pagan</b>		22b. DATE SIGNED <b>7/23/66</b>	
22c PHYSICIAN'S NAME (Type) <b>dr. Pagan</b>		22d. ADDRESS <b>Ridgeley West Va.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>July 25, 1966</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Abe Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hiley Ford, W. Va.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarnelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 27 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Information from birth cert.

09243

## CERTIFICATE OF DEATH

Item 9 Film 6279 6/4/66 mh

09241

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admnssion) a. STATE <b>Md.</b> b. COUNTY <b>Alleg.</b>	
b. CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>89 MIN.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL</b>		d. STREET ADDRESS <b>203 Spruce St.</b>	
3. NAME OF DECEASED (Type or print) First <b>RYAN</b> Middle <b>BABY GIRL</b> Last		4. DATE OF DEATH Month <b>7-</b> Day <b>14</b> Year <b>66</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-66</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <b>NB</b>
11. BIRTHPLACE (County & State, or foreign country) <b>ALLEGANY, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>MELVIN O'NEAL RYAN</b>		14. MOTHER'S MAIDEN NAME <b>MARLENE ANNE MOOREHEAD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Polycystic Kidneys</b> DUE TO (b) <b>(Bilateral Tremendous)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>19:30 to A.M.</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>19</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>F. B. Whitworth</b>		22b. DATE SIGNED <b>7/15/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. F. B. WHITWORTH</b>		22d. ADDRESS <b>CUMBERLAND, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR		ADDRESS	
25a. REC'D BY REGISTRAR DATE <b>JUL 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

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09250

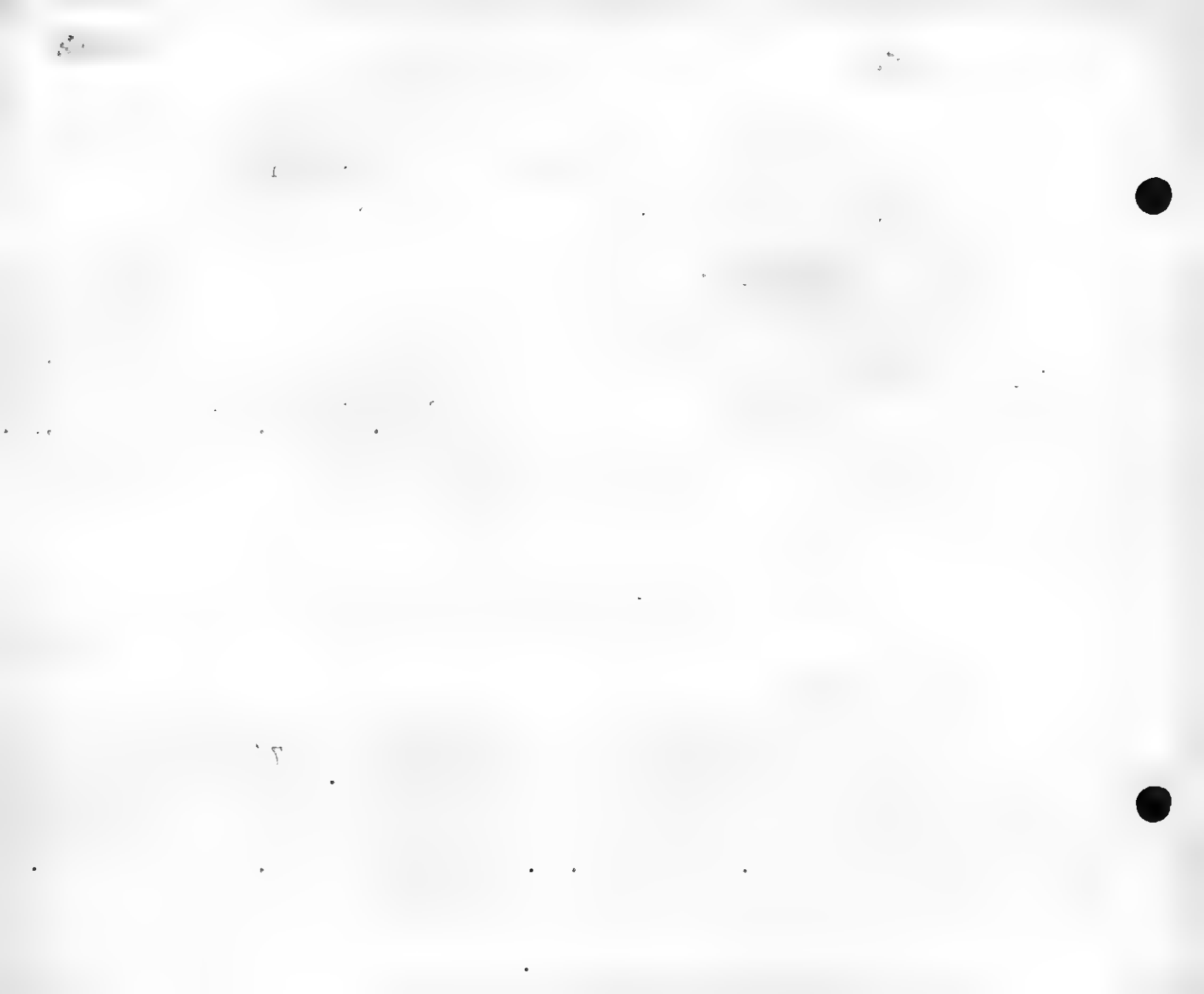
## CERTIFICATE OF DEATH

09242

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN TB <b>5/14/1962</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Allegany County Infirmary</b>		e. STREET ADDRESS <b>811 Roeth Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Silverman, Rachel J.</b>		4. DATE OF DEATH Month <b>July</b> Day <b>1</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1875</b>
9. AGE (In years last birthday) yrs. <b>90</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Syracuse, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Abram Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Schwartzman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>219 44 2400</b>	
17. INFORMANT <b>P.O. Box 599, Allegany County Infirmary records</b>		18. ADDRESS <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertension, degenerative</b> DUE TO (b) <b>Arteriosclerosis, senile</b> DUE TO (c) <b>Refractured Fracture of Hip (Pectoral) Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/14/62</b> , 19__, to <b>7/1/66</b> , 19__, that (I) (we) last saw the deceased alive on <b>6/30/66</b> , 19__, and that death occurred at <b>A. M.</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Leo B. Mathews</b>		22b. DATE SIGNED <b>7/1/1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Leo B. Mathews, M. D.</b>		22d. ADDRESS <b>49 Greene St., Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 5, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeside Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Miami Dade Fla.</b>
24. FUNERAL DIRECTOR <b>William G. Kight</b>		25. REC'D BY REGISTRAR <b>JUL 5 1966</b>	
ADDRESS <b>Cumberland, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please) remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





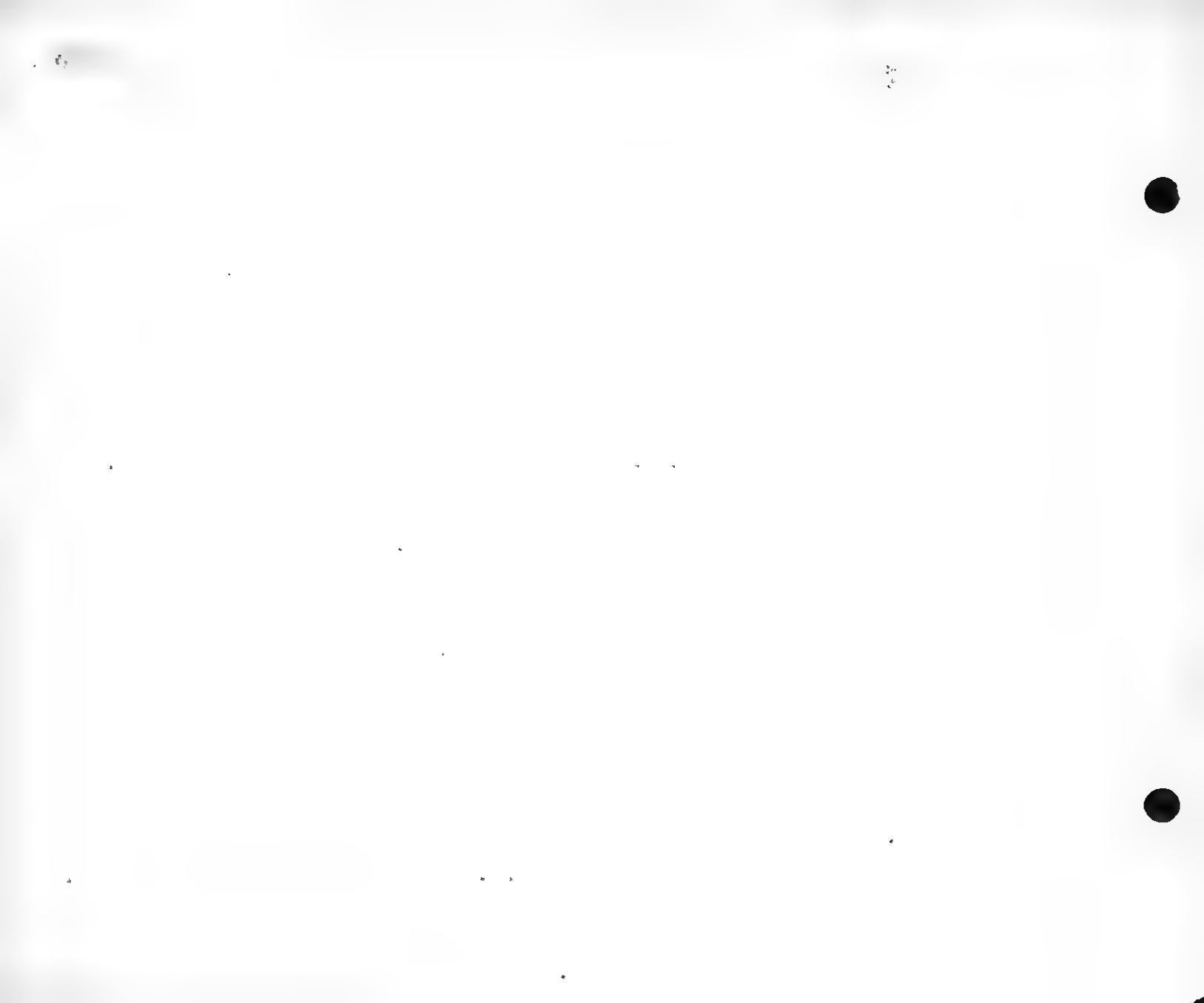
**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN b <b>D O A</b>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>MIDLOTHIAN</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EDGAR</b> Middle <b>SKIDMORE</b> Last						4. DATE OF DEATH Month <b>JULY</b> Day <b>25</b> Year <b>19 66</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 5, 1910</b>		9. AGE (in years last birthday) <b>56</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>LOUIS SKIDMORE</b>						14. MOTHER'S MAIDEN NAME <b>NELLIE DREW</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 2</b>				16. SOCIAL SECURITY NO <b>213-10-5274</b>		17. INFORMANT Address <b>MRS. PEARL SKIDMORE, MIDLOTHIAN, MD.</b>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY <b>1201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>BENEDICT SKITARELIC, M.D.</b>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22. DATE SIGNED <b>July 25, 1966</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>						23b. DATE THEREOF <b>JULY 27, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FB'G. MEMORIAL PARK</b>		23d. LOCATION (City or town) (County) (State) <b>FROSTBURG, MD.</b>	
24. FUNERAL DIRECTOR <b>JOSEPH R. DURST, SR., FROSTBURG, MD.</b>						25a. REC'D BY REGISTRAR DATE <b>JUL 29 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



## CERTIFICATE OF DEATH

09244

C9252

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>8 DAYS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>RT 5</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>W</b> Middle <b>SMITH</b> Last		4. DATE OF DEATH Month <b>JULY</b> Day <b>5</b> Year <b>66</b>	
5. SEX <b>MALE</b>	6. CO. OR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-28-1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired bricklayer &amp; stonemason.</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>74</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Chambersburg, Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>	
13. FATHER'S NAME <b>ADAM SMITH</b>		14. MOTHER'S MA DEN NAME <b>HOLBERT, MARTHA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>214-12-3413</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>5811</b> DUE TO <b>CIRRHOSIS OF THE LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Laurel's Cirrhosis)</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertension &amp; arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>60</b>
20f. (City or town) (County) (State) <b>7/5 66</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>1966-1-15</b> to <b>7/5</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>7/5</b> 19 <b>66</b> , and that death occurred at <b>7/5</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>DR. S. G. WEISMAN</b>		22b. DATE SIGNED <b>7/6/66</b>	22c. PHYSICIAN'S NAME (Type) <b>DR. S. G. WEISMAN</b>
22d. ADDRESS <b>CUMBERLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/7/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>LaVale Alleg Maryland</b>
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



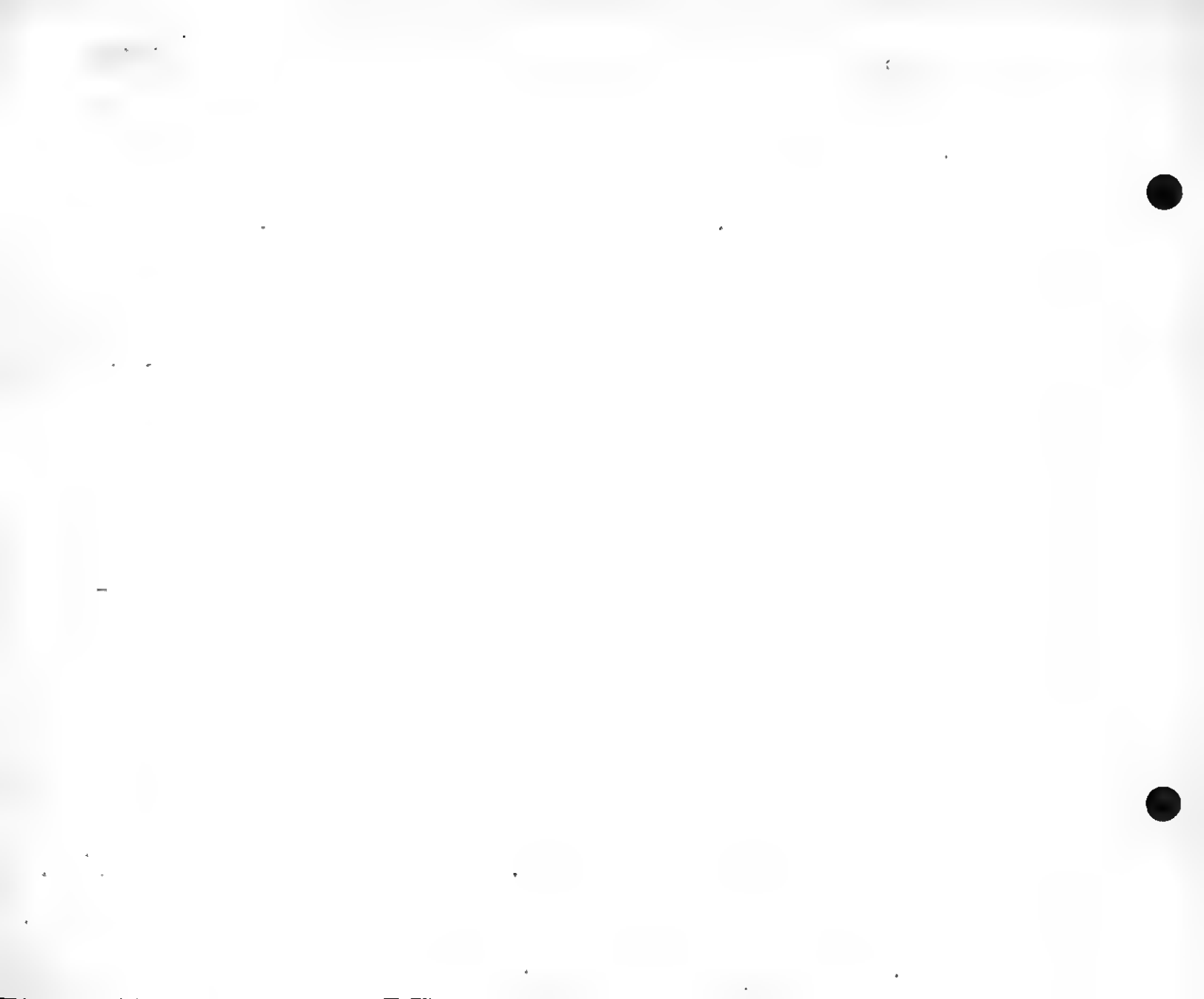
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
09253		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						09245			
1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND						2 USUAL RESIDENCE (Where deceased lived if institut on Residence before admiss on) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY N 16		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Mount Savage Box 623 #11</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>						d. STREET ADDRESS <u>Glen Savage Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Carl</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1966</u>								
5 SEX <u>Male</u>		6 COLOR OR RACE <u>White</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>4/24/06</u>		9 AGE (In years lost birthday) <u>60</u> yrs		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u> Hours <u>66</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Acetone Recovery Dept.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fibres Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Charles J. Smith</u>						14. MOTHER'S MAIDEN NAME <u>Annie Mary Lowery</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>214-07-0658</u>		17. INFORMANT Address <u>Mrs. Kathryn Smith Box 623 Mt. Savage, Md.</u>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION, LEFT</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>CORONARY SCLEROSIS</u> Conditions if any which gave rise to immediate cause (a), stating the underlying cause lost										INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u> <u>---</u> <u>---</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month Day Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED <u>July 19, 1966</u>		
						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Charles Judge</u> Address (Street, city, town, or county) <u>Cumberland, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>			23d. LOCATION (City or town) (County) (State) <u>Cumberland, Allegany, MD.</u>				
24. FUNERAL DIRECTOR ADDRESS <u>H. Wayne George Cumberland, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JUL 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in the event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09246

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		2. USUAL RESIDENCE (Where deceased lived) <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>904 Louisiana Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ellen</u> Last <u>Stegmaier</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1917</u>
9. AGE (in years last birthday) <u>48</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Telephone Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam G. McCrorie</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Ziler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-7903</u>	
17. INFORMANT <u>Dr. James G. Stegmaier</u>		Address <u>Cumb. Md.</u> <u>904 Louisiana Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ANASARCA, GENERALIZED</u> DUE TO (c) <u>PORTAL CIRRHOSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>Days</u> <u>---</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONTINUING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>July 1, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/1/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Burial Park</u>		23d. LOCATION (City or town) (County) (State) <u>Cumberland, Allegany Md.</u>	
24. FUNERAL DIRECTOR <u>H. Wayne George</u>		ADDRESS <u>Cumberland, Maryland</u>	
25a. REC'D BY REGISTRAR <u>JUL 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09255

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>640 Shriver Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u> d. STREET ADDRESS <u>640 Shriver Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marian</u> Middle <u>R.</u> Last <u>Stuiber</u>		4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/16/89</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> 12. BIRTHPLACE (County & State, or foreign country) <u>Cumberland Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel Trovett</u>		14. MOTHER'S MAIDEN NAME <u>Lillie Chase</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Wilhelmina M. Rae</u>		Address <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>generalized atherosclerosis</u> OU E TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-2-</u> , 19 <u>64</u> , to <u>7-6-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6-26-</u> 19 <u>66</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Lewis Brings</u>		22b. DATE SIGNED <u>7-7-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nethercrest Burial Ph.</u>	23d. LOCATION (City, town or county) (State) <u>Cumberland Md</u>
24. FUNERAL DIRECTOR <u>Lewis Stein Inc.</u>		25a. REC'D BY REGISTRAR <u>  </u> 25b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JUL 11 1966</u>			



09256

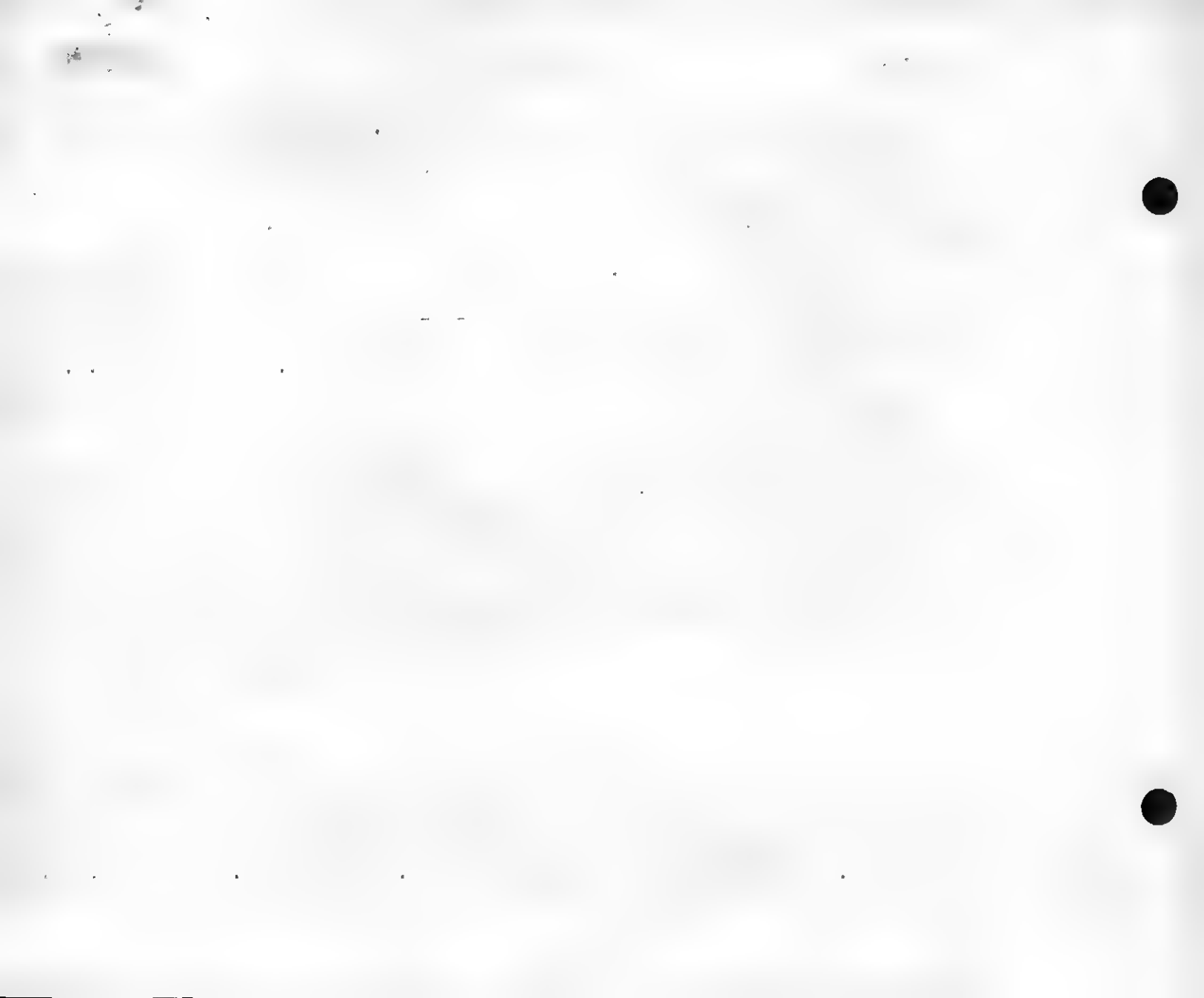
CERTIFICATE OF DEATH

09248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		2. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SACRED HEART HOSPITAL</b>		d. STREET ADDRESS <b>502 OLDTOWN RD.</b>	
3 NAME OF DECEASED (Type or print) <b>GRACE K. WAGNER</b>		4 DATE OF DEATH Month <b>JULY</b> Day <b>26</b> Year <b>19 66</b>	
5 SEX <b>female</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>9-22-97 1897</b>
9. AGE (n years last birthday) <b>68</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>18</b> Hours <b>18</b> Min <b>18</b>	
10a. USUAL OCC. PAT ON (Give kind of work done during most of work ng life, even if ret red) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTH-PLACE (City & State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH (D) Martin J. Breighner</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH (D) Bloome</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PTS' CHART</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Post necrotic cirrhosis</b> DUE TO <b>5810</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>September 19 65</b> to <b>July 26, 19 66</b> , that (I) (we) last saw the deceased alive on <b>July 26 19 66</b> , and that death occurred at <b>7 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>W. Spiggle</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. SPIGGLE &amp; GLICK</b>		22d. ADDRESS <b>126 N. SNOWWOOD ST. CUMBERLAND, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>July 29, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Md. Allegany</b>
24. FUNERAL DIRECTOR <b>James F. Scarcelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



09249

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09257

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY N 1b <b>?</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>		e. STREET ADDRESS <b>85-J</b>	
3 NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Florine</b> Last <b>Wagoner</b>		4. DATE OF DEATH Month <b>July</b> Day <b>10</b> Year <b>1966</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 24, 1902</b>
9 AGE (In years last birthday) <b>65</b>		10 UNDER 1 YEAR Months <b>10</b> Days <b>19</b> Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Fort Ashby, W. Va.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Adams</b>		14 MOTHER'S MAIDEN NAME <b>Margaret Dowden</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>no</b>		16 SOCIAL SECURITY NO <b>John H. Wagoner, Fort Ashby, W. Va.</b>	
17 INFORMANT <b>John H. Wagoner, Fort Ashby, W. Va.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>----</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspected an <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>July 10, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county) <b>Cumberland, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>July 13, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Fort Ashby, W. Va.</b>
24. FUNERAL DIRECTOR <b>James F. Scarcelli, Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 12 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/66

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09258

09250

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Route #2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Route #2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Arch</u> Last <u>Wentling</u>		4 DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 18, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired) <u>Retired Supt.- Hillcrest Burial Park</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (In years last birthday) <u>65 yrs.</u>
11 BIRTHPLACE (State or foreign country) <u>Cumberland Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walker Wentling</u>		14 MOTHER'S MAIDEN NAME <u>May Gurley</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOC. SEC. NO. <u>214-05-6803</u>	17 INFORMANT <u>Mrs. Mildred Wentling</u> Address <u>Route #2 Cumberland, Md.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1901</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/8/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cumberland Alleg Maryland</u>	
24 FUNERAL DIRECTOR <u>Ruth E. Silcox</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 8 1966</u>	
ADDRESS <u>Cumberland Maryland 21502</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

22. DATE SIGNED

July 5, 1966

Cumberland, Md.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

09259

CERTIFICATE OF DEATH

09251

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>501 Warren St.</u>				d. STREET ADDRESS <u>501 Warren St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>W.</u> Last <u>Wigley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1966</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21, 1872</u>	9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph White</u>				14. MOTHER'S MAIDEN NAME <u>Jane Boor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Wanita Myers.</u>		Address <u>Cumberland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis, Chn. degenerative</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio sclerosis, general, atherosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. L. B. Mathews</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>DR. L. B. MATHEWS</u> <u>49 Grease Street</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 6, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md.</u>	
24. FUNERAL DIRECTOR <u>Louis Stein, Inc.</u>				ADDRESS <u>Cumberland, Md.</u>			
25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH					
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
09260			CERTIFICATE OF DEATH		09252
1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>543 GREENE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ROBERT SHRYVER WILKINSON</b>			4. DATE OF DEATH Month <b>JULY</b> Day <b>11</b> Year <b>1966</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 30, 1897</b>		9. AGE (In years last birthday) yrs. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman &amp; buyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail store</b>		11. BIRTHPLACE (County & State, or foreign country) <b>CUMBERLAND, MD.</b>	
13. FATHER'S NAME <b>CHARLES N. WILKINSON</b>			14. MOTHER'S MAIDEN NAME <b>CLARA DREBING</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes W.W.#1</b>		16. SOCIAL SECURITY NO. <b>214-07-1208</b>		17. INFORMANT <b>Mrs. Viola Wilkinson</b> Address <b>543 Greene St. MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cordial Failure</b> DUE TO (b) <b>myocardial infarct, acute, lateral</b> DUE TO (c) <b>A.S. Cardiovascular disease with coronary insuff.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>48 hours</b> <b>9 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus, mild 9 years</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>11 July, 1966</b> , that (I) (we) last saw the deceased alive on <b>11 July 1966</b> , and that death occurred at <b>5 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>W. Alfred Van Orner</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12 July 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM A. VAN ORNER</b>		22d. ADDRESS <b>122 S. CENTRE ST., CUMBERLAND, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>7/14/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>		25a. REC'D BY REGISTRAR <b>JUL 15 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09261

CERTIFICATE OF DEATH

09253

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>1206 LaVale Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WELLINGTON</b> Middle <b>EARL</b> Last <b>YUTZY</b>		4. DATE OF DEATH Month <b>July</b> Day <b>5</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1897</b>
9. AGE (In years lost birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee- Celanese Corp of Amer.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Garrett County Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jonas Yutzy</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Knauer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>	
16. SOCIAL SECURITY NO. <b>220-07-6609</b>		17. INFORMANT <b>Mrs. Margaret Yutzy</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Acute myocardial infarction</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }		INTERVAL BETWEEN ONSET AND DEATH <b>moments</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>5-3</b> , 19 <b>66</b> , to <b>7-5</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>6-8</b> , 19 <b>66</b> , and that death occurred at <b>12 P.M.</b> from causes and on the date stated above.	
22a. SIGNATURE <b>W.C. Spiggle</b>		22b. DATE SIGNED <b>7-6-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Wayne C. Spiggle, M.D.</b>		22d. ADDRESS <b>126 N. Smallwood St. Cumberland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/8/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland Alleg Maryland</b>	
24. FUNERAL DIRECTOR <b>Ruth E. Silcox</b>		25a. REC'D BY REGISTRAR <b>JUL 8 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

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